

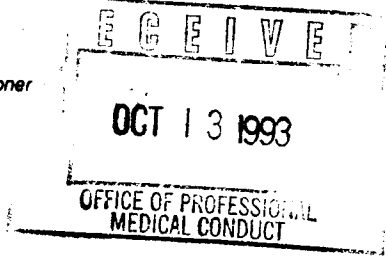


STATE OF NEW YORK DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner



October 8, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael A. Hiser, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Ronald M. Levy, M.D.
6325 Sheridan Drive
Williamsville, NY 14221

Jeffrey A. Lazroe, Esq.
405 Brisbane Building
Buffalo, New York 14203

RE: In the Matter of Ronald M. Levy, M.D.

Dear Mr. Hiser, Mr. Lazroe and Dr. Levy:

Enclosed please find the Determination and Order (No. BPMC-93-161) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

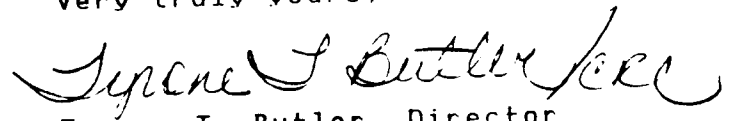
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Very truly yours,

A handwritten signature in cursive script that reads "Tyrone T. Butler". The signature is written in dark ink and is positioned above the typed name and title.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER ; DETERMINATION
OF ; AND
RONALD M. LEVY, M.D. ; ORDER
_____X

ORDER NO. BPMC-93-161

WILLIAM W. FALDON, M.D., Chairman, MS. NANCY J.

MORRISON and ARLENE B. REED-DELANEY, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230 (10)(e) of the Public Health Law. MARSHALL J. GRAUER, ESQ. served as the Administrative Officer for the Hearing Committee on the first three days of the Hearing. MICHAEL P. McDERMOTT, ESQ., Administrative Law Judge, served as the Administrative Officer on all subsequent hearing days.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

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SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	February 1, 1993
Amended Statement of Charges:	June 3, 1993
Pre-Hearing Conference:	April 1, 1993

Hearing Dates:

April 22, 1993
April 23, 1993
May 6, 1993
June 17, 1993
June 18, 1993
July 1, 1993
July 7, 1993
July 8, 1993

Place of Hearing:

Radisson Hotel
4243 Genesee Street
Buffalo, New York 14225

Date of Deliberations:

August 11, 1993

Petitioner appeared by:

Peter J. Millock, Esq.
General Counsel
NYS Department of Health
By: Michael A. Hiser, Esq.
Assistant Counsel

Respondent appeared by:

Jeffrey A. Lazroe, Esq.
405 Brisbane Building
Buffalo, New York 14203

WITNESSES

For the Petitioners:

1. Patient I
2. Patient A
3. Louis J. Fein
4. Joseph Dubreville
5. Patient D
6. David Bonacci, M.D.
7. Jean Caprio
8. Silvia Olarte, M.D.
9. Dorothy Ciccarella

For the Respondent:

1. Patient 3
2. Frederick Munschauer, M.D.
3. Jessie Ann Levy
4. Ronald M. Levy, M.D.,
the Respondent

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with physical contact of a sexual nature; willful harassment, abuse, or intimidation; moral unfitness; gross negligence; gross incompetence; negligence on more than one occasion; incompetence on more than one occasion; fraud in the practice of medicine; wilfully making or filing a false report; and failing to maintain records.

The Charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Ronald M. Levy, M.D., the Respondent, was authorized to practice medicine in New York State on June 23, 1969, by the issuance of license number 103809 by the New York State Education Department. The Respondent is registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from 6325 Sheridan Drive, Williamsville, New York, 14221-4801 (Pet's. Ex. 2).

FINDINGS AS TO PATIENT A

2. The Respondent provided medical care in the form of psychiatric treatment to Patient A and also to her husband, Patient B, at various times from December 1989 through April 1990, at the Respondent's office at 6325 Sheridan Drive, Williamsville, New York and at Patient A and B's residence in Buffalo, New York. At the time, Patient A was 22 years old and Patient B was 27 years old (Pet's. Ex. 3).

CONFLICTING TESTIMONY (PATIENT A/RESPONDENT)

PATIENT A TESTIFIED:

3. a) She started therapy sessions with the Respondent in December 1989. Shortly after Christmas, the Respondent began telephoning her and her husband at home (Tr. 117-118.).
- b) In late January, 1990, the Respondent had contact with Patient B's mother. Following that contact, Patient A and B discussed with the Respondent the fact that

Patient B's parents wanted Patient B to return to Long Island for a visit. Patients A and B were concerned that Patient B's parents might try to involuntarily commit Patient B for hospitalization. The Respondent advised Patients A and B that, if Patients A and B were married, Patient B's parents could not involuntarily commit Patient B. Shortly thereafter, Patients A and B were married (Tr. 127-128).

- c) On numerous occasions from January 1990 through and including April 1990, the Respondent told Patient A that she "owed" him for his role in arranging her marriage to Patient B without her having to sign a prenuptial agreement (Tr. 129)
- d) In mid-February, 1990, the Respondent contacted Patients A and B at home by telephone. He was upset because of conflicts with his wife. They invited him over for dinner and he stayed and resided with them from approximately February 12 through February 23, 1990 (Tr. 133-140).
- e) On numerous occasions during the time the Respondent lived with Patients A and B at their residence, he engaged in physical contact of a sexual nature with Patient A, including fondling her breasts and genitals, and having oral contact with her genitals (Tr. 133-144).
- f) After he moved out of their apartment in late February 1990, the Respondent continued having physical contact

of a sexual nature with Patient A. This continued through April 1990 at his office during Patient A's appointments. Her appointments often times were late in the evening when no other patients were there (Pet's. Ex. 3 pp. 35, 36, 38, 39, 42, 45, 46) Tr. 147-148, 156-158).

- g) During the time that the Respondent lived with Patients A and B he told Patient A to disrobe in his presence, ostensibly for the purpose of allowing him to view her body and comment on her weight gain/loss. After he had moved out of their residence, he continued making these demands on Patient A from late February 1990 through April 1990 (Tr. 133-144, 147-148, 156-158).
- h) From January 1990 through April 1990, the Respondent gave gifts to Patient A, including a crystal, a book on the healing power of crystals, and a statue (Pet's. Exs. 21 & 22; Tr. 112-116).
- i) On numerous occasions between January 1990 and April 1990, the Respondent telephoned Patient A at her home to complain about his wife; to tell her how much sadness and pain he was in; and to seek emotional comfort from her (Tr. 158).
- j) Between January 1990 and April 1990, the Respondent suggested to Patient A that she leave her husband and move with him to California (Tr. 159).

- k) During the period February 1990 through April 1990, the Respondent owned more than one hand gun. This was known to Patient A. On at least two occasions, the Respondent exhibited a hand gun to Patient A in his office and threatened to commit suicide (Tr. 162-164).
- l) The Respondent has a daughter by the name of "Shannon Sheedy." On March 22, 1990, the Respondent gave Patient A two prescriptions he had written in the name of "Shannon Sheedy" for the medications L-Thyroxin and Synthroid. He requested that Patient A have the prescriptions filled and give the medication to him. The next time Patient A saw the Respondent, she gave him the medications. The prescription is marked as having been filled on March 23, 1990 (Pet's. Ex. 6; Tr. 160-161).
- m) The Respondent went to Florida for approximately one week in early April 1990. While in Florida, he spoke to Patient A by telephone and threatened to commit suicide. Patient A contacted the Respondent's previous treating therapist, Dr. Sidney Rosen, to seek Dr. Rosen's intervention in the situation. Patient A knew of Dr. Rosen from prior conversations with the Respondent (Tr. 165-167).
- n) While the Respondent was still in Florida, Patient A decided to terminate treatment with him. The Respondent returned to Buffalo on April 17, 1990. On April 19,

1990, Patient A met with him and informed him that she and Patient B were ending treatment (Pet's. Ex. 3, pp. 43-45; Tr. 167-170).

- o)** On April 20, 1990, the Respondent called Patient B's parents and told them of a plan by Patient A and B to kill Patient B's parents (Tr. 309).
- p)** On April 20, 1990 the Respondent also called Crisis Services Inc., a Buffalo, New York suicide prevention service, to report Patients A and B (Tr. 309).

THE RESPONDENT TESTIFIED:

- 4. a)** He never advised Patients A and B to get married (Tr. 1367).
- b)** He never told Patient A that she "owed" him for arranging her marriage with Patient B (Tr. 1244).
- c)** He never moved in to live with Patients A and B (Tr. 1249).
- d)** He never touched Patient A and he never had oral sex with her genitals (Tr. 1249).
- e)** He never asked Patient A to disrobe (Tr. 1249, 1342).
- f)** He admitted giving Patient A statue of a sphinx. He testifies that it was a replica of an art object that had been in Freud's art collection and that he had received it as a gift from the Ciba-Geigy Drug Company. He gave the statue to Patient A because she expressed an interest in it and asked to have it, and he felt it was

of benefit for her therapy. He denied giving Patient A crystals or a book on the healing power of crystals (Tr. 1235-1239).

- g) He denied fighting with his wife (Tr. 1174).
- h) He denied seeking emotional comfort from Patient A (Tr. 1243).
- i) He denied asking Patient A to leave her husband and move with him to California (Tr. 1243)
- j) He claims that Patient A volunteered to pick up the medications for his daughter, Shannon Sheedy (Tr. 1247).
- k) He denied ever calling Patient A and threatening to commit suicide (Tr. 1241).
- l) He admits to calling Patient B's parents, his own lawyer and the local police on Long Island where Patient B's parents lived, to advise them that Patient A and B had a plan to kill the parents. He claims that he made these calls because he thought Patient B's parents might be in danger and also because he thought he was no longer able to control Patients A and B (Tr. 1218-1220).
- m) He admits that he did call Crisis Services Inc. on April 20, 1990, to report Patients A and B. He said he made the call because they threatened to commit suicide (Tr. 1219-1220).
- n) He claims that he obtained the consent of both Patients A and D for their joint therapy sessions (Tr. 1204)

5. In addition to the conflicts in the testimony of Patient A and the Respondent already noted, Patient A was prone to exaggeration and even contradicted her own testimony.

- a) Patient A appeared before the Hearing Committee with brown hair, no makeup and wearing business attire consisting of skirt, blouse and jacket. She denied remembering what she wore when she was under the Respondent's care. She denied wearing any make up (Tr. 102).

In later testimony, Patient A acknowledged that she had black hair and had dressed in black at the time but again denied wearing white make-up (Tr. 274, 292, 403).

However, several other witnesses contradicted Patient A, and testified that she had long black hair, dressed in black and used a lot of white make-up at the time she was being treated by the Respondent (Tr. 64, 896, 961, 1030, 1178-1179).

- b) Patient A repeatedly told others that doctors were in love with her (Tr. 902, 1048, 1066, 1184).

Dr. Munschauer testified that Patient A told him that she felt some sexual tension between her and a Dr. Jacobs (Tr. 968).

Patient A denies that she ever told Dr. Munschauer that any physician had made sexual advances towards her (Tr. 257-260).

- c) Patient A told the Respondent that she had extrasensory perception (Tr. 204-205).
- d) Patient A claims that she was oppressed by supernatural creatures in her Victorian house in Buffalo, New York, and that they followed her to Westbury, Connecticut (Tr. 207-210).
- e) Patient A admitted to using marijuana but denied using any other illegal drugs (Tr. 213).
- f) Patient A denied ever taunting, hitting, or bending Patient B's fingers (Tr. 227-228). However, in a letter to his former psychiatrist, a Dr. Gerstanzang, Patient B, accused Patient A of taunting him, screaming insults at him, pinching his arm, bending his fingers and daring him to hit her (Resp's. Ex. F).
- g) About one month after she stopped seeing the Respondent in April, 1990, Patient A prepared a seven page handwritten document setting out what purports to be a history of the relationship between herself, the Respondent and Patient B. The document contains no mention whatever that the Respondent performed oral sex on Patient A or that they had a sexual relationship of any nature whatsoever (Tr. 239-245).
- h) During her testimony, Patient A admitted to engaging in oral sex with an unidentified individual prior to the time she alleges the Respondent engaged in oral sex with her. However, she denied ever engaging in oral sex when

she was interviewed by Dr. Munschauer in January, 1990 (Tr. 251-255).

- 1) Patient A first testified that she was a TV producer, to find musical talent and make videos and send them out on tour. She implied that she and her husband, Patient B, were, "Independent owners, executive producers." In later testimony she revised that testimony to say that she was training to be a director. She also made exaggerated claims about an alleged appearance on the Arsenio Hall Show (Tr. 99, 198-199, 274,357).

6. On January 18, 1990, the Respondent billed for fourteen hours of therapeutic services for Patients A and B. The services were not performed (Pet's. Ex. 3, p. 79; Tr. 1313-1316).

CONCLUSIONS AS TO PATIENT A

Patient A was not a credible witness. She told too many conflicting stories, with too many contradictions and exaggerations and with no corroborating witnesses.

The Respondent appeared credible on most issues but he did display a hesitancy in discussing others. Importantly, other witnesses confirmed his version of many of the details regarding his relationship with Patient A.

The Hearing concludes as follows:

1. After a review of the entire record regarding sexual issues, the Hearing Committee finds that the evidence is

inconclusive, and therefore the Committee concludes that there is not a preponderance of evidence to support Patient A's allegations of sexual misconduct by the Respondent.

2. The Respondent gave Patient A a statue of a sphinx which he had received from the Ciba-Geigy Drug Company. The gift giving was not a violation of acceptable medical standards under the circumstances.

3. The Hearing Committee discounts Patient A's allegations that:

- a) The Respondent contacted Patient A at her residence by telephone on numerous occasions to complain about his wife, to express love and affection for Patient A, and to seek emotional comfort from Patient A.
- b) The Respondent suggested that Patient A leave her husband and move with him to California.
- c) The Respondent, while on vacation in Florida, in March 1990, spoke to Patient A by telephone and threatened to commit suicide.
- d) The Respondent physically moves into Patient A and B's residence from February 12 through February 23, 1990.

4. The Hearing Committee also concludes that the Respondent billed for 21 hours of therapeutic services to Patients A and B on January 18, 1990, which services were not performed.

FINDINGS AS TO PATIENT B:

7. The Respondent provided medical care in the form of

psychiatric treatment to Patient B, a 27 year old male, at various times from December 1989 through April 1990, at the Respondent's office, and at Patient B's residence in Buffalo, New York (Pet's. Ex. 3).

8. On or about January 11, 1990, the Respondent prescribed Haldol for Patient B in the amount of 60 mg. per day to be taken, 5 mg./ hour. Haldol is a potent anti-psychotic drug (Tr. 612-613, 1259).

9. The usual dosage of Haldol is 10-30 mg/day (Tr. 613).

10. The Physicians Desk Reference indicates a dosage of up to 100 mg of Haldol/day for severely disturbed or inadequately controlled patients (Pet's. Ex. 24).

CONCLUSION AS TO PATIENT B

The Hearing Committee concludes that Respondent's prescribing of Haldol, 60 mg/day for Patient B, to be taken 5 mg/hour, did not violate accepted standards of medical practice.

FINDINGS AS TO PATIENT C

11. Patient C received medical care in the form of psychiatric treatment by the Respondent between approximately April, 1988 and March, 1989. Patient C had just turned 14 when she began treatment. Patient C's therapy with the Respondent involved an intense therapeutic relationship. The Respondent's records of treatment of Patient C contains no clear-cut

termination note (Pet's. Ex. 10; Tr. 670, 862).

12. Between April, 1989 and September, 1989, the Respondent employed Patient C at his office on weekends. Patient C was paid approximately \$20 for a days work. In that setting, Patient C worked with another of the Respondent's patients who was employed to do secretarial work. The Respondent did not document any rationale for his employment of Patient C (Pet's. Ex. 10; Tr. 34, 673-674).

13. In 1990, the Respondent was working on a research paper dealing with obsessive compulsive behavior. The Respondent arranged for Patient C to do the typing on that paper, which she did between May, 1990 and December, 1990 (Tr. 681-682, 1466).

14. Approximately once or twice a week, the Respondent came to Patient C's house and picked her up and drove her to his office to work on the paper (Tr. 682-683).

15. On several occasions between May, 1990 and May, 1992, the Respondent was overheard on the telephone by Patient C's mother telling Patient C that he loved her. Patient C's mother recognized the Respondent's voice because she had previously spoken with him on the telephone on a number of occasions (Tr. 671-672, 693-694).

16. In late November 1990, the Respondent attended a conference in Carlsbad, California for which he received a Continuing Medical Education Credit. On or about November 28, 1990, the Respondent sent two greeting cards and a postcard to Patient C, all addressed to her at her high school. The cards

could be considered personal in nature. Patient C was 16 years old at the time (Pet's. Exs. 11, 12, 13).

17. On January 18, 1992, while driving his car from Canada to the United States through the U.S. Customs Service facility at the Rainbow Bridge near Buffalo, New York, the Respondent was stopped and searched by U.S. Customs officers. Patient C, then 17 years old, was the only passenger in the Respondent's car (Pet's. Ex. 8, p. 1).

18. During his conversations with Customs officials, the Respondent gave contradictory explanations of his relationship with Patient C. He said that Patient C and he were just friends; that Patient C was his former secretary; that Patient C was a former patient who worked for him off the books; and that Patient C was a current patient for whom he was providing medication (Pet's. Ex. 26; Tr. 456, 462).

19. The Respondent made an oral declaration that he had no drugs or weapons in his possession. In fact, after a search by Customs officials, the Respondent was found to have in his possession a loaded 25 caliber pistol. The Respondent's car was also found to have in it a quantity of Darvon, Xanax, and Valium (Pet's. Exs. 25 and 26).

20. On February 20, 1992, the Respondent sent Patient C a greeting card which could be considered personal in nature (Pet's. Ex. 14).

21. On March 5, 1992, the Respondent again sent a greeting card which could be considered personal in nature to

Patient C (Pet's. Ex. 15).

HEARING COMMITTEE DISCUSSION AS TO PATIENT C

The Respondent testified that he did tell Patient C that he loved her, but that he did it because Patient C had expressed on several occasions that she felt unloved, and he thought that it would benefit her to know that she was loved (Tr. 1396). Even Patient C's mother acknowledged that her daughter had told her, "Dr. Levy loved her like a friend." "When she said she loved him as - - she said, Mom, it's not like that, I care about him, he's my friend. She also intimated that it was the same for her" (Tr. 710-711).

The Respondent and his wife both testified that Patient C did work part-time on weekends in the Respondent's office to make some extra money for Christmas. They both thought it was a good idea, that it would be a positive influence in her life, and would benefit her self esteem. She was hired to do typing, not research (Tr. 1077-1078, 1081, 1385).

Patient C's mother testified, "Jessy (Respondent's wife) used to take her out for lunch on these Saturdays. She befriended her. She was very kind to her and Patient C, related very well to her also they were becoming friendly." (Tr. 676).

The Respondent and his wife both testified that they went to Canada in January 1992 to visit friends and relatives. While at their hotel they received a telephone call from Patient

C, saying that she was stuck in Toronto and needed a ride home. The Respondent and his wife decided that he should drive Patient C home rather than to let her hitchhike. The Respondent's car was stopped by Customs and after declaring that they had no guns or drugs, the car was searched and a pistol and prescriptions drugs were found. Neither the Respondent nor Patient C were arrested. The pistol was confiscated and they were released. There was no follow-up by Customs (Tr. 1085-1092, 1400-1414).

Much has been made of the cards which the Respondent sent to Patient C (Pet's. Exs. 11-15).

The Respondent's wife testified that it was at her suggestion that the cards were sent and that she and the Respondent picked them out (Tr. 1084-1303).

All of the cards are signed "Love, Ron." The Respondent's wife testified that this is the way the Respondent signed all greeting cards. "They were casual postcards. Greeting cards. Nothing to them" (Tr. 1087).

Three of the cards (Pet's. Ex's. 11, 12 and 13) have the notation "1-2-3" which the Petitioner would have the Committee believe is a code for "I love you."

The Respondent testified that he had discussions with Patient C regarding her problems with mathematics in school and told her that math was as easy as 1-2-3. The notation "1-2-3" on the greeting cards was meant to encourage Patient C to do her math and make it easy (Tr. 1392).

One of the greeting cards, Pet's. Ex. 15, has the

message "There is only you." The Respondent testified that this was a perfect card to send to Patient C because he was "trying to tell her there is only her to consider, there is only her that's going to college, live with the experience and live with the kind of education experience she's going to receive . . ." (Tr. 1396).

Greeting card, Pet's. Ex. 14, has the message "Just wanted to tell you I'm glad we're married."

Both the Respondent and his wife testified that the card was a joke to make up for the Respondent's having snapped at Patient C because of a missing file at the office (Tr. 1085-1087, 1093-1094).

CONCLUSIONS AS TO PATIENT C

In the absence of any contradictory evidence the Hearing Committee accepts the testimony of the Respondent and his wife regarding their relationship with Patient C.

The Hearing Committee concludes that the Respondent and his wife were overindulgent in their relationship with Patient C, (picking her up and dropping her off at work, taking her to lunch, sending her greeting cards, etc.) and exercised poor judgement.

FINDINGS AS TO PATIENT D

22. The Respondent provided medical care in the form of psychiatric treatment to Patient D, a 38 year old female, at various times from August 1989 to April 1990 (Pet's. Ex. 28).

23. Patient D testified that she went to the

Respondent's office on January 18, 1990 and that the Respondent placed his hands against the wall around her shoulders and told her, "I will be the man that no one else has ever been" (Tr. 509-510).

The Respondent denies making such a statement but did testify that he may have said something to that effect that he could be the person to help her with her problems (Tr. 1443).

24. On January 18, 1990, the Respondent met with Patient D in his office for an evening appointment. After speaking on the phone to someone who the Respondent described as a suicidal patient, the Respondent told Patient D that he had asked the patient to come into the office. The Respondent asked Patient D to stay and meet with the suicidal patient in order to provide therapeutic assistance. The patient that Respondent described as suicidal was Patient A (Tr. 500, 507-509).

25. Prior to Patient A's arrival at the office, the Respondent provided confidential patient information about Patient A to Patient D, including Patient A's psychiatric history, current problems, marital situation, and the identity of her then-boyfriend's family. Patient A never complained about these disclosures (Tr. 508, 517, 563).

26. When Patient A arrived, the Respondent arranged for Patient D to talk with Patient A for an extended period of time, up to three to four hours, to provide suicide intervention therapy. Patient D was uneasy about this experience (Tr. 509, 516, 1206-1207).

27. The Respondent also placed Patient D in contact with another of his patients, Patient 2. The Respondent contacted Patient D and requested that she provide therapeutic assistance to Patient 2. The Respondent's records for Patient D contain no reference to this request (Pet's. Ex. 28; Tr. 497, 504-507).

28. The Respondent's records for Patient A and Patient D do not contain any reference to this lengthy therapeutic intervention, nor is any permission by either patient allowing a breach of confidentiality noted (Pet's. Exs. 3 and 28, Tr. 885-886).

29. The Respondent offered Patient D several jobs during the time that she was an active psychiatric patient. The Respondent offered to employ Patient D in his office as a co-therapist, with the intent that she could use her experience in sexual harassment matters to advise the Respondent's patients. Patient D rejected each of the offers of employment (Tr. 496-499).

CONCLUSION AS TO PATIENT D

The Hearing Committee accepts the Respondent's representation that Patient D probably misinterpreted his words when she claimed that he said, "I can be the man for you that no other man can be." After the alleged conversation, Patient D left the office and the Respondent made no attempt to stop her.

In arranging for Patient D to provide therapeutic assistance to two of the Respondent's patients, the Respondent used poor judgment, but it does not constitute either negligence

or incompetence.

When he arranged for the therapeutic session which included Patients A and D, the Respondent obtained permission to divulge confidential information regarding Patient A. He discussed the situation with both Patients and neither one objected.

It was not a violation of medical ethics or the acceptable standard of medical care for the Respondent to have offered to employ Patient D in his office. It may have been poor judgment but it did not constitute negligence or incompetence.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified).

At the Hearing on July 8, 1993, the Petitioner withdrew charges B (2) as specified in the Statement of Charges.

FIRST SPECIFICATION: (Physical contact of a sexual nature).

NOT SUSTAINED as to any of the charges.

SECOND SPECIFICATION: (Willful harassment, abuse or intimidation).

NOT SUSTAINED as to any of the charges.

THIRD THROUGH FIFTH SPECIFICATIONS: (Moral unfitness).

NOT SUSTAINED as to any of the charges.

SIXTH THROUGH NINTH SPECIFICATIONS: (Gross negligence).

NOT SUSTAINED as to any of the charges.

TENTH THROUGH THIRTEENTH SPECIFICATIONS: (Gross Incompetence)

NOT SUSTAINED as to any of the charges.

FOURTEENTH SPECIFICATION: (Negligence on more than one occasion).

NOT SUSTAINED as to any of the charges.

..

FIFTEENTH SPECIFICATION: (Incompetence on more than one
occasion).

NOT SUSTAINED as to any of the charges.

SIXTEENTH SPECIFICATION : (Fraud in the Practice of Medicine).

SUSTAINED as to the charge specified in Paragraph A(5) of the
Statement of Charges.

NOT SUSTAINED as to the charges specified in Paragraphs A(8) and
A(9) of the Statement of Charges.

SEVENTEENTH SPECIFICATION: (Willfully making or filing a false
report).

SUSTAINED as to the charges specified in Paragraph C(5) of the
Statement of Charges.

EIGHTEENTH SPECIFICATION: (Failing to maintain records).

SUSTAINED as to the charges specified in Paragraphs C(5)(b)(2)
of the Statement of Charges.

GENERAL OBSERVATIONS OF THE HEARING COMMITTEE

Some of Patient A's Medical Records were missing and this appeared to disadvantage both parties.

The medical records for Patient A that were available did not contain a treatment plan, did not indicate the severity of Patient A's illness and, if she was in fact suicidal, the records do not indicate suicidal precautions.

Dr. Munschauer saw Patient A only once but he was able to recognize that Patient A had a preoccupation with sexual attractions that could endanger a physician's reputation. There is little evidence that the Respondent took any precautions to protect against this situation or that he even addressed the issue with the patient.

The Respondent knew that Patient A was a dangerous patient who had attacked the reputation of other physicians who had treated her, however, he took the risk of becoming involved because of greed.

There is no doubt that the Respondent was motivated by greed in his continuing professional relationship with Patients A and B.

Patient B was the son of very wealthy parents and the Respondent exploited Patients A and B because of that wealth. On January 18, 1990, he billed for fourteen hours of therapeutic services for Patients A and B which were not performed. He even admitted billing Patient B's parents, alleging that care was given

to Patient B, when in fact the care was given to Patient A (Tr. 1315-1316).

The testimony of Patient A was inconclusive, leaving more questions than answers. The Petitioner had too few witnesses; there was no corroboration of Patient A's testimony; and the Hearing Committee was left with the impression that she was either lying or greatly exaggerating on many issues.

Patients B and C did not testify and the Hearing Committee regrets not having had the benefit of hearing their testimony.

The Hearing Committee found an overindulgence on the part of both the Respondent and his wife in their relationship with Patient C. They showed poor judgment in hiring Patient C; in picking her up and dropping her off at home; in sending the greeting cards; in taking her to lunches; in driving her home from Canada, and in allowing her to stay overnight in their home. However, the Hearing Committee concludes that none of these activities constitutes either negligence or incompetence.

The Respondent and his wife were over-involved with Patient C, and the Hearing Committee has the impression that they treated her as the daughter they never had.

While the Hearing Committee has voted to sustain one charge of fraud, one charge of wilfully making and filing a false report and one charge of failing to maintain records, the Hearing Committee is deeply concerned about the obvious pattern of poor judgment displayed by the Respondent. The Hearing Committee is

concerned that the Respondent's poor judgment, if not corrected, may ultimately cross the line of acceptable medical practice in the future. Hopefully, these Hearings have brought this problem to the Respondent's attention and he will respond accordingly.

HEARING COMMITTEE DETERMINATION

The Hearing Committee has voted to SUSTAIN one charge of fraud; one charge of willfully making or filing a false report and one charge of failing to maintain records against the Respondent.

The Hearing Committee determines that the Respondent should be CENSURED AND REPRIMANDED for the charges which were SUSTAINED and further that he be fined five thousand (\$5,000.00) dollars for the SUSTAINED charge of fraud in the practice of medicine.

ORDER

It is hereby **ORDERED** that

1. The Respondent is **CENSORED AND REPRIMANDED**.
2. A fine in the amount of Five Thousand (\$5,000.00) is imposed upon the Respondent. Payment of the fine shall be made within thirty (30) days of the effect date of this **ORDER** to the New York State Department of Health, Bureau of Accounts Management, Corning Tower Building, Room 1344, Empire State Plaza, Albany, New York, 12237.

3. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal services or by certified or registered mail.

DATED: Rochester, New York
October 4, 1993

William W. Faloon, M.D.
WILLIAM W. FALOON, M.D.
Chairman

NANCY J. MORRISON
ARLENE B. REED-DELANEY, M.D.

ANY CIVIL PENALTY NOT PAID BY THE DATE PRESCRIBED
HEREIN SHALL BE SUBJECT TO ALL PROVISIONS OF LAW
RELATING TO DEBT COLLECTION BY THE STATE OF NEW YORK.
THIS INCLUDES BUT IS NOT LIMITED TO THE IMPOSITION OF
INTEREST, LATE PAYMENT CHARGES AND COLLECTION FEES;
REFERRAL TO THE NEW YORK STATE DEPARTMENT OF TAXATION
AND FINANCE FOR COLLECTION; AND NON-RENEWAL OF PERMITS
OR LICENSES (TAX LAW § 171(27); STATE FINANCE LAW § 18;
CPLR § 5001; EXECUTIVE LAW § 32).

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

-----X

IN THE MATTER : STATEMENT
OF : OF
RONALD M. LEVY, M.D. : CHARGES

-----X

RONALD M. LEVY, M.D., the Respondent, was authorized to practice medicine in New York State on June 23, 1969, by the issuance of license number 103809 by the New York State Education Department. The Respondent was last registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from 6325 Sheridan Drive, Williamsville, New York 14221-4801.

FACTUAL ALLEGATIONS

A. Respondent provided medical care in the form of psychiatric treatment to Patient A (patients are identified in the Appendix) and Patient B, Patient A's husband, at various times from December 1989 through April 1990 at the Respondent's office at 6325 Sheridan Drive, Williamsville, New York 14221-4801 (hereafter, the "Office"), and at the residence of Patient A and B in Buffalo, New York. Patient A was 22 years old, and Patient B was 27 years old.

1. Respondent, on numerous occasions from February 1990 through April 1990 at the office during Patient A's appointments, and at Patient A's residence in Buffalo, New York (hereafter "residence") engaged in physical contact of a sexual nature with Patient A, including the following:
 - a. Respondent fondled Patient A's breasts and genitals.
 - b. Respondent had oral contact with Patient A's genitals.
2. Respondent, on numerous occasions from February 1990 through April 1990 at the office during Patient A's appointments and at Patient A's residence, told Patient A to disrobe in Respondent's presence.
3. Respondent, from January 1990 through April 1990, engaged in inappropriate contact with Patient A, including the following:
 - a. Respondent gave gifts to Patient A, including a crystal, a book on the healing powers of crystals, and a statue.
 - b. Respondent contacted Patient A at her residence by telephone on numerous occasions to complain about Respondent's wife, to express love and affection for Patient A, and to seek emotional comfort from Patient A.
 - c. Respondent suggested that Patient A leave her husband and move to California with Respondent.
 - d. Respondent, while on vacation in Florida in March 1990, spoke to Patient A by telephone and threatened to commit suicide.
4. Respondent, between approximately February 12 and February 23, 1990, engaged in inappropriate contact with Patient A by physically moving into the residence of Patient A and her husband, Patient B, in Buffalo, New York.
5. Respondent billed for 21 hours of therapeutic services to Patients A and B on January 18, 1990, which services were not performed.

6. Respondent, on numerous occasions from January 1990 through and including April 1990, told Patient A that she "owed" him for his role in arranging her marriage to Patient B without preparation and execution of an ante-nuptial agreement.
7. Respondent, on at least two occasions from February 1990 through April 1990 at his office, exhibited a hand gun to Patient A and threatened to commit suicide.
8. Respondent, on or about March 22, 1990, gave Patient A two prescriptions in the name of "Shannon Sheedy" for L-thyroxine and synthroid, and requested that Patient A fill the prescriptions and give the medication to him.
9. Respondent, on or about April 20, 1990, willfully harassed Patients A and B by falsely advising Crisis Services, a Buffalo, New York suicide prevention service, that Patients A and B were suicidal and should undergo a mental health assessment by Crisis Services as a basis for possible involuntary commitment.

B. Respondent provided medical care in the form of psychiatric treatment to Patient B, a 27 year old male, at various times from December 1989 through April 1990 at Respondent's office, and at Patient B's residence in Buffalo, New York.

1. Respondent prescribed an inappropriately large initial dose of Haldol for Patient B.
2. Respondent, inappropriately prescribed and/or provided Clomipramine to Patient B, concurrent with Trazodone, another antidepressant medication.
3. Respondent, between approximately February 12 and February 23, 1990, engaged in inappropriate contact with Patient B by physically moving into the residence of Patient B and his wife, Patient A, in Buffalo, New York.

C. Respondent provided medical care in the form of psychiatric treatment to Patient C, a 14 year old female, at various times from April 1988 to March 1989. Respondent thereafter maintained contact with Patient C.

1. Respondent, from approximately April 1989 through September 1989, engaged in inappropriate, nontherapeutic contact with Patient C, his former psychiatric patient, by having Patient C (then 15 years old) work in his office on weekends.
2. Respondent, between approximately May, 1990, and December, 1990, engaged in inappropriate, nontherapeutic contact with Patient C, by having Patient C (then 16 years old) work with him as a research assistant on topics related to her prior diagnosis.
3. Respondent, on several occasions between May 1990 and May 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by telling Patient C (then between 16 and 18 years old) that he loved her.
4. Respondent, in November 1990, engaged in inappropriate, nontherapeutic contact with Patient C, by sending two cards to her that were personal and intimate in nature. Patient C was then 16 years old.
5. Respondent, on or about February 20, 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by sending her a card that was personal and intimate in nature. Patient C was then 17 years old.
6. Respondent, on or about March 5, 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by sending her a card that was personal and intimate in nature. Patient C was then 17 years old.
7. Respondent, between approximately May 1992 and August 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by employing Patient C at his medical office.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PHYSICAL CONTACT OF A SEXUAL NATURE

Respondent, a psychiatrist, is charged with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient, within the meaning of N.Y. Educ. Law sec. 6530(44) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509 and 8 NYCRR §29.4(a)(5)] in that Petitioner charges:

1. The facts in Paragraphs A and A.1.a and/or A and A.1.b.

SECOND SPECIFICATION

WILLFUL HARASSMENT, ABUSE, OR INTIMIDATION

Respondent is charged with wilfully harassing, abusing, or intimidating a patient either physically or verbally, under N.Y. Educ. Law sec. 6530(31) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509 and 8 NYCRR §29.2(a)(2)] in that Petitioner charges:

2. The facts in Paragraphs A and A.1.a, and A and A.1.b, A and A.2, A and A.6, A and A.7, and/or A and A.9.

THIRD AND FOURTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine, within the meaning of N.Y. Educ. Law sec. 6530(20) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR 29.1(b)(5)] in that Petitioner charges:

3. The facts in paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.c, A and A.5, A and A.6, A and A.8, and/or A and A.9.
4. The facts in paragraphs C and C.3, C and C.4, C and C.5, and/or C and C.6.

FIFTH THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law sec. 6530(4) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges:

5. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.5, A and A.6, A and A.7, and/or A and A.8.
6. The facts in Paragraphs B and B.1, B and B.2, and/or B and B.3.
7. The facts in Paragraph C and C.3, C and C.4, C and C.5, and/or C and C.6.

EIGHTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law sec. 6530(6) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509(2)] in that Petitioner charges:

8. The facts in Paragraphs A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.6, and/or A and A.7.
9. The facts in Paragraphs B and B.1, B and B.2, and/or B and B.3.
10. The facts in Paragraphs C and C.3, C and C.4, C and C.5, and/or C and C.6.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

11. The facts in paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.a, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, C and C.1,

C and C.2, C and C.3, C and C.4, C and C.5, C and C.6,
and/or C and C.7.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

12. The facts in paragraphs A and A.3.a, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, and/or C and C.7.

THIRTEENTH SPECIFICATION
FRAUD IN PRACTICE OF MEDICINE

Respondent is charged with fraud in the practice of medicine under N.Y. Educ. Law §6530(2) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed the following:

13. The facts in paragraphs A and A.5, A and A.8, and/or A and A.9.

DATED: Albany, New York
February 18, 1993

Peter D. Van Buren

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

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

-----X

IN THE MATTER : FIRST AMENDED
OF : STATEMENT
RONALD M. LEVY, M.D. : OF CHARGES

-----X

RONALD M. LEVY, M.D., the Respondent, was authorized to practice medicine in New York State on June 23, 1969, by the issuance of license number 103809 by the New York State Education Department. The Respondent was last registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from 6325 Sheridan Drive, Williamsville, New York 14221-4801.

FACTUAL ALLEGATIONS

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1. Respondent, on numerous occasions from February 1990 through April 1990 at the office during Patient A's appointments, and at Patient A's residence in Buffalo, New York (hereafter "residence") engaged in physical contact of a sexual nature with Patient A, including the following:
 - a. Respondent fondled Patient A's breasts and genitals.
 - b. Respondent had oral contact with Patient A's genitals.
2. Respondent, on numerous occasions from February 1990 through April 1990 at the office during Patient A's appointments and at Patient A's residence, told Patient A to disrobe in Respondent's presence.
3. Respondent, from January 1990 through April 1990, engaged in inappropriate contact with Patient A, including the following:
 - a. Respondent gave gifts to Patient A, including a crystal, a book on the healing powers of crystals, and a statue.
 - b. Respondent contacted Patient A at her residence by telephone on numerous occasions to complain about Respondent's wife, to express love and affection for Patient A, and to seek emotional comfort from Patient A.
 - c. Respondent suggested that Patient A leave her husband and move to California with Respondent.
 - d. Respondent, while on vacation in Florida in March 1990, spoke to Patient A by telephone and threatened to commit suicide.
4. Respondent, between approximately February 12 and February 23, 1990, engaged in inappropriate contact with Patient A by physically moving into the residence of Patient A and her husband, Patient B, in Buffalo, New York.
5. Respondent billed for 21 hours of therapeutic services to Patients A and B on January 18, 1990, which services were not performed.

6. Respondent, on numerous occasions from January 1990 through and including April 1990, told Patient A that she "owed" him for his role in arranging her marriage to Patient B without preparation and execution of an ante-nuptial agreement.
7. Respondent, on at least two occasions from February 1990 through April 1990 at his office, exhibited a hand gun to Patient A and threatened to commit suicide.
8. Respondent, on or about March 22, 1990, gave Patient A two prescriptions in the name of "Shannon Sheedy" for L-thyroxine and synthroid, and requested that Patient A fill the prescriptions and give the medication to him.
9. Respondent, on or about April 20, 1990, willfully harassed Patients A and B by falsely advising Crisis Services, a Buffalo, New York suicide prevention service, that Patients A and B were suicidal and should undergo a mental health assessment by Crisis Services as a basis for possible involuntary commitment.

B. Respondent provided medical care in the form of psychiatric treatment to Patient B, a 27 year old male, at various times from December 1989 through April 1990 at Respondent's office, and at Patient B's residence in Buffalo, New York.

1. Respondent prescribed an inappropriately large initial dose of Haldol for Patient B.
2. Respondent, inappropriately prescribed and/or provided Clomipramine to Patient B, concurrent with Trazodone, another antidepressant medication.
3. Respondent, between approximately February 12 and February 23, 1990, engaged in inappropriate contact with Patient B by physically moving into the residence of Patient B and his wife, Patient A, in Buffalo, New York.

7/27/93
7/8/93

C. Respondent provided medical care in the form of psychiatric treatment to Patient C, a 14 year old female, at various times from April 1988 to March 1989 Respondent thereafter maintained contact with Patient C.

1. Respondent, from approximately April 1989 through September 1989, engaged in inappropriate, nontherapeutic contact with Patient C, his former psychiatric patient, by having Patient C (then 15 years old) work in his office on weekends.
2. Respondent, between approximately May, 1990, and December, 1990, engaged in inappropriate, nontherapeutic contact with Patient C, by having Patient C (then 16 years old) work with him as a research assistant on topics related to her prior diagnosis.
3. Respondent, on several occasions between May 1990 and May 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by telling Patient C (then between 16 and 18 years old) that he loved her.
4. Respondent, in November 1990, engaged in inappropriate, nontherapeutic contact with Patient C, by sending two cards to her that were personal and intimate in nature. Patient C was then 16 years old.
5. Respondent, on or about January 18, 1992, while driving his car from Canada to the United States through U.S. Customs Services facilities at the Rainbow Bridge near Buffalo, N.Y., was stopped and searched by U.S. Customs Officers. Patient C, then 17 years old, was the only passenger in Respondent's car.
 - a. Respondent, on January 18, 1992, engaged in inappropriate, nontherapeutic contact with Patient C by travelling with Patient C.
 - b. During the stop, Respondent variously told Customs Officers that:
 - (1) Patient C and he were "just friends;" Patient C was his former secretary; Patient C was a former

patient who worked for him "off the books;" and that

- ✓ (2) Patient C was his current patient for whom he was providing medications.
- c. Respondent made a written and oral declaration that he had no drugs or weapons in his possession, when in fact he was found by Customs Officers to have in his possession a quantity of Darvon, Xanax, Valium, and a loaded .25 caliber pistol.
6. Respondent on or about February 20, 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by sending her a card that was personal and intimate in nature. Patient C was then 17 years old.
7. Respondent, on or about March 5, 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by sending her a card that was personal and intimate in nature. Patient C was then 17 years old.
8. Respondent, between approximately May 1992 and August 1992, engaged in inappropriate, nontherapeutic contact with Patient C, by employing Patient C at his medical office.

D. Respondent provided medical care in the form of psychiatric treatment to Patient D, a thirty-eight year old female, at various times from August 1989 through April 1990.

1. Respondent, in or about October 1989, in his office at Sheridan Drive, Williamsville, New York, placed his hands against the wall around Patient D's shoulders, and told her, "I can be the man for you that no other man can be."
2. Respondent, in or about January 1990, inappropriately arranged for Patient D to provide therapeutic assistance to two others of Respondent's patients.
3. Respondent, in or about January, 1990, divulged confidential patient information about another of Respondent's patients to Patient D, including the patient's psychiatric history, current problems, and marital situation.

4. Respondent, in or about February 1990, sought to employ Patient D in his office variously as a secretary/receptionist, a research assistant, and a co-therapist.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PHYSICAL CONTACT OF A SEXUAL NATURE

Respondent, a psychiatrist, is charged with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient, within the meaning of N.Y. Educ. Law sec. 6530(44) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509 and 8 NYCRR §29.4(a)(5)] in that Petitioner charges:

1. The facts in Paragraphs A and A.1.a and/or A and A.1.b.

SECOND SPECIFICATION

WILLFUL HARASSMENT, ABUSE, OR INTIMIDATION

Respondent is charged with willfully harassing, abusing, or intimidating a patient either physically or verbally, under N.Y. Educ. Law sec. 6530(31) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509 and 8 NYCRR §29.2(a)(2)] in that
"Petitioner charges:

2. The facts in Paragraphs A and A.1.a, and A and A.1.b, A and A.2, A and A.6, A and A.7, A and A.9, and/or D and D.1.

THIRD THROUGH FIFTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine, within the meaning of N.Y. Educ. Law sec. 6530(20) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR 29.1(b)(5)] in that Petitioner charges:

3. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.c, A and A.5, A and A.6, A and A.8, and/or A and A.9.
4. The facts in Paragraphs C and C.3, C and C.4, C and C.5.b (1 and 2), C and C.5.c, C and C.6, and/or C and C.7.
5. The facts in Paragraph D and D.1.

SIXTH THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law sec. 6530(4) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges:

6. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.5, A and A.6, A and A.7, and/or A and A.8.
7. The facts in Paragraphs B and B.1, B and B.2, and/or B and B.3.

8. The facts in Paragraph C and C.3, C and C.4, C and C.5.a, C and C.6 and/or C and C.7.
9. The facts in Paragraphs D and D.1, D and D.2, D and D.3, and/or D and D.4.

TENTH THROUGH THIRTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law sec. 6530(6) (McKinney Supp. 1993) [formerly N.Y. Educ. Law sec. 6509(2)] in that Petitioner charges:

10. The facts in Paragraphs A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.6, and/or A and A.7.
11. The facts in Paragraphs B and B.1, B and B.2, and/or B and B.3.
12. The facts in Paragraphs C and C.3, C and C.4, C and C.5.a, C and C.6 and/or C and C.7.
13. The facts in Paragraphs D and D.1, D and D.2, D and D.3 and/or D and D.4.

FOURTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

14. The facts in paragraphs A and A.1.a, A and A.1.b, A and A.2, A and A.3.a, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5.a, C and C.6, C and C.7, C and C.8, D and D.1, D and D.2, D and D.3, and/or D and D.4.

FIFTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

15. The facts in paragraphs A and A.3.a, A and A.3.b, A and A.3.c, A and A.3.d, A and A.4, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5.a, C and C.6, C and C.7, C and C.8, D and D.1, D and D.2, D and D.3, and/or D and D.4.

SIXTEENTH SPECIFICATION

FRAUD IN PRACTICE OF MEDICINE

Respondent is charged with fraud in the practice of medicine under N.Y. Educ. Law §6530(2) (McKinney Supp. 1993) [formerly N.Y. Educ. Law §6509(2)] in that Petitioner charges that Respondent committed the following:

16. The facts in paragraphs A and A.5, A and A.8, A and A.9, and/or C and C.5.b(1 and 2).

SEVENTEENTH SPECIFICATION

WILLFULLY MAKING OR
FILING A FALSE REPORT

Respondent is charged with willfully making or filing a false report, within the meaning of N.Y. Educ. Law §6530(21) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed the following:

17. The facts in Paragraphs C and C.5.c.

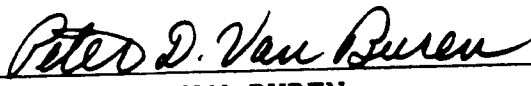
EIGHTEENTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with failing to maintain a record for Patient C which accurately reflects the evaluation and treatment of Patient C, within the meaning of N.Y. Educ. Law § 6530(32) (McKinney Supp. 1993), in that Petitioner charges:

18. The facts in Paragraph C and C.5.b.2.

DATED: Albany, New York
June 3, 1993


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