Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

C. Maynard Guest, M.D.
Executive Secretary

July 30, 1992

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Richard Frank Miller, M.D.
5570 Main Street
Room 203
Williamsville, New York 14221

RE: License #082824
Effective Date - 8/6/92

Dear Dr. Miller:

Enclosed please find Order #BPMC 92-62 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect seven (7) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0614

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Joel L. Daniels, Esq.
444 Statler Towers
Buffalo, New York 14202

E. Marta Sachey, Esq.

bcc: Chris Hyman
Peter VanBuren
James Campbell
Kenneth Spooner
Faith Schottenfeld
Vincent Martiniano
Anne Bohenek

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

IN THE MATTER :

OF : ORDER

RICHARD FRANK MILLER, M.D. : #BPMC 92-62

Upon the Application of RICHARD FRANK MILLER, M.D. (Respondent) to Surrender his license as a physician in the State of New York, which Application is made a part hereof, it is

ORDERED, that the Application and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that Respondent shall not apply for the restoration of Respondent's license until at least one year has elapsed from the effective date of this order; and it is further

ORDERED, that this Order shall take effect as of the date of the personal service of this Order upon Respondent, upon receipt by Respondent of this Order via certified mail, or seven days after mailing of this Order via certified mail, whichever is earliest.

SO ORDERED,

DATED: 30 July 1992

Charles J. Vacanti

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER OF RICHARD FRANK MILLER, M.D.	APPLICATION TO SURRENDER LICENSE

STATE OF NEW YORK)
ss.:
COUNTY OF ERIE)

RICHARD FRANK MILLER, M.D., being duly sworn, deposes and says:

1. I was authorized to practice medicine in New York State on or about August 20, 1959, by the issuance of license number 082824 by the New York State Education Department. I am currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 5570 Main Street, Room 203, Williamsville, New York, 14221.

2. I understand that the New York State Board for Professional Medical Conduct has charged me with forty-nine specifications of professional misconduct. A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as "Exhibit A."

3. I am applying to the State Board for Professional Medical Conduct ["the Board"] for permission to surrender my license as a physician in the State of New York on the grounds that I admit guilt to the seventh through twenty-third and twenty-sixth

through forty-ninth specifications of professional medical misconduct and the factual allegations in paragraphs A1 through A4, B1 through B6, C1 through C5, D1 through D10, E1 through E2, F1 through F3, G1 through G3, H1 through H3, I1 through I5, J1 through J2, and K1 through K4 set forth in the Statement of Charges in full satisfaction of the charges.

4. I hereby make this Application to the Board and request that it be granted.

5. I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provision of the Public Health Law.

6. I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with the same.

7. I agree that, in the event the Board grants my Application, an order of the Chairperson of the Board may be issued striking my name from the roster of physicians in the State of New York without further notice to me.

8. I further agree that the order of the Chairperson shall include a provision that I shall not apply for the restoration of my license until at least one (1) year has elapsed from the effective date of the service of such order. I understand that such application is not automatically granted but may be granted or denied.

9. I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

X Richard Frank Miller M.D.

RICHARD FRANK MILLER, M.D.
Respondent

Sworn to before me this

28th day of July, 1992.

Jeff W. [illegible]

NOTARY PUBLIC
REGISTERED IN SCHENECTADY COUNTY
STATE OF NEW YORK
REGISTRATION NO. 4660302 EXPIRES 7/31/93

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

IN THE MATTER OF RICHARD FRANK MILLER, M.D.	APPLICATION TO SURRENDER LICENSE

The undersigned agree to the attached Application to Surrender License of the Respondent.

Date: 7/28, 1992

RICHARD FRANK MILLER, M.D.
Respondent

Date: 7/28, 1992

JOEL L. DANIELS, Esq.
Attorney for Respondent

Date: 7/28, 1992

E. MARTA SACHEY
Associate Counsel
Bureau of Professional
Medical Conduct

Date: July 30, 1992

KATHLEEN M. TANNER
Director, Office of
Professional Medical Conduct

Date: 30 July, 1992

CHARLES J. VACANTI, M.D.
Chairperson, State Board for
Professional Medical Conduct

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

IN THE MATTER	:	STATEMENT
OF	:	OF
RICHARD FRANK MILLER, M.D.	:	CHARGES

RICHARD FRANK MILLER, M.D., the Respondent, was authorized to practice medicine in New York State on August 20, 1959 by the issuance of license number 082824 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 5570 Main Street, Room 203, Williamsville, New York 14221-5734.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A [patients are identified in Appendix A] from approximately June 12, 1989 through approximately September 21, 1989 at Respondent's office at 5570 Main Street, Williamsville, New York [hereafter "office"].

1. Respondent, on several occasions in approximately the end of July, 1989 and in August, 1989 at the end of Patient A's appointments at his office, hugged Patient

A by putting his arm around Patient A's shoulder in a side to side hug, which was not medically justified.

2. Respondent, on several occasions in approximately September 1989 at the end of Patient A's appointments at his office, hugged Patient A with frontal hugs, which was not medically justified and/or was physical contact of a sexual nature.

3. Respondent, on approximately September 21, 1989, at the end of Patient A's appointment at his office, pulled Patient A towards him, hugged Patient A with a frontal hug and kissed Patient A on the mouth, which was not medically justified and/or was physical contact of a sexual nature.

4. Respondent, with regard to the evaluation, treatment, and/or maintenance of records of Patient A, failed to do the following:

   a. Respondent failed to record an adequate history of Patient A.

   b. Respondent failed to develop and/or record treatment goals or plans for Patient A.

   c. Respondent failed to record adequate progress notes of his sessions with Patient A.

   d. Respondent failed to maintain adequate records for Patient A.

B. Respondent provided psychiatric care to Patient B from approximately May 30, 1989 through approximately August 17, 1989 at his office.

1. Respondent, on approximately May 30, 1989 at the end of Patient B's appointment at his office, hugged Patient B by putting his arm around Patient B's shoulders in a side to side hug and kissed Patient B on the head, which was not medically justified.

2. Respondent, on approximately June 13, 1989 at the end of Patient B"s appointment at his office, hugged Patient B in a side to side hug, kissed Patient B on her cheek, and touched and pressed the side of Patient

B's breast, which was not medically justified and/or was physical contact of a sexual nature.

3. Respondent, on approximately June 24, 1989 during the course of Patient B's appointment at his office in discussing Patient B's diet, told Patient B "Don't lose weight where it counts, you know, the breasts. Be sure to keep the womanly curves" or words to such effect, which was not medically justified and/or was verbal abuse.

4. Respondent, on approximately July 13, 1989 during the course of Patient B's appointment at his office in discussing Patient B's diet, again told Patient B not to lose weight in her breasts and further told her that her "breasts were her one redeeming feature" or words to such effect, which was not medically justified and/or was verbal abuse.

5. Respondent, on approximately August 17, 1989, at the end of Patient B's appointment at his office, in response to Patient B asking him "What is wrong with you, is it your back?", yelled at Patient B "No, it's my crotch. I've pulled a muscle there" and Respondent grabbed himself in his crotch area, which was not medically justified and/or was verbal abuse.

6. Respondent, with regard to the evaluation, treatment, and/or maintenance of records of Patient B, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals or plans for Patient B.

   b. Respondent failed to record adequate progress notes of his sessions with Patient B.

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

C. Respondent provided psychiatric care to Patient C from approximately March 24, 1986 through October 1, 1986 at his office.

1. Respondent, on numerous occasions from approximately April 7, 1986 through approximately June 18, 1986 at

the end of Patient C's appointments at his office, hugged Patient C and kissed her on the cheek, which was not medically justified.

2. Respondent, on approximately October 1, 1986 during Patient C's appointment at his office, told Patient C he was going to Africa and made comments regarding African women's breasts and that he would have to be careful, which was not medically justified and/or was verbal abuse.

3. Respondent, on approximately October 1, 1986 at the end of Patient C's appointment at his office, hugged Patient C and kissed her on the mouth, which was not medically justified and/or was physical contact of a sexual nature, and Patient C discerned that Respondent had an erection.

4. Respondent, often during Patient C's appointments at his office, commented on Patient C's appearance and on several occasions told Patient C her "breasts looked nice" or words to such effect, which was not medically justified and/or was verbal abuse.

5. Respondent, with regard to the evaluation, treatment, and/or maintenance of records of Patient C, failed to do the following:

   a. Respondent failed to obtain and/or record an adequate history of Patient C.

   b. Respondent failed to develop and/or record treatment goals or plans for Patient C.

   c. Respondent failed to record adequate progress notes of his sessions with Patient C.

   d. Respondent failed to maintain adequate records for Patient C.

D. Respondent provided psychiatric care to Patient D from approximately March 21, 1990 through approximately May 13, 1991 at his office. Respondent prescribed drugs for Patient D and recorded Patient D's drug regimen in his office records, as specified in Appendix I.

1. Respondent, on numerous occasions at the end of Patient D's appointments at his office, hugged Patient D by putting his arm around Patient D's shoulders in a side to side hug and kissed Patient D on the top of her head or on her forehead, which was not medically justified.

2. Respondent, on numerous occasions at Patient D's appointments at his office, addressed Patient D as "sweetie" or "babe", which was not medically justified.

3. Respondent, on January 2, 1991 at Patient D's appointment at his office, held Patient D's cheeks in his hands and kissed Patient D on the mouth while he wished her a Happy New Year, which was not medically justified and/or was physical contact of a sexual nature.

4. Respondent, in May 1990, employed Patient D to do filing work in his office.

5. Respondent prescribed Stelazine [all drugs are identified in Appendix B] for Patient D, which was not indicated and/or without recording the indications.

6. Respondent prescribed Adipex-P, Mellaril, Meprobamate, Moban, Serentil, Tenormin and/or Tenuate Dospan for Patient D, which were not indicated and/or without recording the indications.

7. Respondent prescribed Desyrel, Imipramine and Prozac for Patient D in combination which was not indicated and/or contraindicated and/or without recording the indications.

8. Respondent prescribed Desyrel, Imipramine, and Valium for Patient D in combination which was not indicated and/or contraindicated and/or without recording the indications.

9. Respondent prescribed Moban and Serentil to Patient D in combination which was not indicated and/or without recording the indications.

10. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient D, failed to do the following:

    a. Respondent failed to develop and/or record treatment goals or plans for Patient D.

b. Respondent failed to adequately monitor and/or record Patient D's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his treatment of Patient D.

c. Respondent failed to address with Patient D, and/or record that he had done so, that Patient D "in the month of July 1990...attempted suicide by overdosing her medication", although Respondent in a report of approximately January, 1991, communicated such information to the New York State Department of Social Services.

d. Respondent failed to record in his office records that he prescribed Adipex-P, Buspar, Cogentin, Fiorinal, Imipramine, Meprobamate, Moban, Prolixin, Serentil, Tenormin, and/or Tenuate Dospan for Patient D and/or failed to record the instructions for use and/or indications for such drugs.

e. Respondent failed to record in his office records that he prescribed Desyrel for Patient D until October 15, 1990 when he charted "...the same meds. with the addition of a little Desyrel at night, 100mg", although Respondent first prescribed such drug on or about April 3, 1990.

f. Respondent failed to record in his office records that he prescribed Stelazine for Patient D until November 27, 1990 when he charted "will try a small dose of Stelazine to see if this will be helpful...and add this to her medical regime", although Respondent first prescribed such drug on April 5, 1990.

g. Respondent failed to maintain adequate records for Patient D.

E. Respondent provided psychiatric care to Patient E from at least approximately May 25, 1985 through at least July 8, 1991 at various times at his office and at various times by mail. Respondent prescribed drugs for Patient E and recorded Patient E's drug regimen in his office records, as specified in Appendix II.

1. Respondent prescribed Stelazine, Dexedrine, and/or Valium for Patient D, which were not indicated and/or without recording the indications.

2. Respondent, with regard to the evaluation, treatment, and/or maintenance of records of Patient E, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals or plans for Patient E.

   b. Respondent failed to adequately monitor and/or record Patient E's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his treatment of Patient E.

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

F. Respondent saw Patient F in consultation on April 8, 1990 at Buffalo Columbus Hospital, Buffalo, New York during Patient F's admission for detoxification and provided psychiatric care to Patient F from approximately May 8, 1990 through approximately June 6, 1990 at his office. Respondent prescribed drugs for Patient F and recorded Patient F's drug regimen in his office records, as specified in Appendix III.

1. Respondent prescribed Xanax for Patient F who had a history of addiction to Xanax, which therefore was not indicated and/or contraindicated.

2. Respondent prescribed Loxitane and/or Mellaril for Patient F which was not indicated and/or contraindicated and/or without recording the indications.

3. Respondent, with regard to the evaluation, treatment and/or maintenance of records of Patient F, failed to do the following:

a. Respondent failed to develop and/or record treatment goals or plans for Patient F.

b. Respondent failed to record in his office records that he prescribed Tenormin, Mellaril, and/or Loxitane for Patient F and/or failed to record the instructions for use and/or indications for such drugs.

c. Respondent failed to record in his office records that on May 8, 1990 he had prescribed Xanax 0.5 mg for Patient F but rather recorded that he prescribed Xanax 0.25 mg.

d. Respondent, on May 23, 1990, failed to prescribe Desyrel for Patient F and again prescribed Tofranil, despite recording in his office records that "Pt. had difficulty [with] side effect...[s]witched to Desyrel..."

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

G. Respondent provided psychiatric care to Patient G from approximately February 24, 1986 through approximately October 23, 1989. Respondent prescribed drugs for Patient G and recorded Patient G's drug regimen in his office records, as specified in Appendix IV.

1. Respondent failed to recommend to Patient G, and/or record that he had done so, on a sufficient number of occasions that Patient G undergo appropriate treatment for chemical dependency.

2. Respondent prescribed Xanax and/or Valium for Patient G, which was not indicated and/or contraindicated and/or without recording the indications.

3. Respondent with regard to the evaluation, treatment and/or maintenance records of Patient G, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals or plans for Patient G.

b. Respondent failed to adequately monitor Patient G's substance abuse.

c. Respondent failed to address with Patient G, and/or record that he had done so, Patient G's April 15, 1987 involuntary admission to the Niagara Falls Memorial Medical Center, Niagara Falls, New York.

d. Respondent failed to address with Patient G, and/or record that he had done so, Patient G's August 24, 1988 involuntary admission for suspected drug overdose to the Niagara Falls Memorial Hospital Medical Center, Niagara Falls, New York.

e. Respondent failed to record in his office records that he prescribed Desyrel, Etrafon, Halcion, Inderal LA, Loxitane, Prozac, Robaxin, Sinequan, and/or Symmetrel for Patient G and/or failed to record the instructions for use and/or indications for such drugs.

f. Respondent failed to adequately monitor and/or record Patient G's response to pharmacotherapy and/or psychotherapy.

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

H. Respondent provided psychiatric care to Patient H from approximately August 2, 1990 through approximately January 21, 1991. Respondent prescribed drugs for Patient H and recorded Patient H's drug regimen in his office records, as specified in Appendix V.

1. Respondent prescribed Stelazine for Patient H which was not indicated and/or without recording the indication.

2. Respondent prescribed Adipex-P and/or Dexedrine for Patient H, which was not indicated and/or without recording the indication.

3. Respondent with regard to the evaluation, treatment and/or maintenance of records of Patient H, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals for Patient H.

   b. Respondent failed to record in his office records that he prescribed Buspar and Inderal LA for Patient H and/or failed to record the instructions for use and/or indications for such drugs.

   c. Respondent failed to record in his office records that he prescribed Stelazine and Artane for Patient H until the entry dated September 12, 1989, although Respondent began prescribing such drugs on September 1, 1989.

   d. Respondent failed to record in his office records that he prescribed Dexedrine for Patient H until the entry dated January 23, 1990 and recorded "same meds" in the entry dated January 2, 1990, although Respondent began prescribing the drug on December 19, 1989.

   e. Respondent, in his office record entry dated January 23, 1990, failed to record that he prescribed Dexedrine Span 15 mg. for Patient H on January 23, 1990 but rather recorded that he had prescribed Dexedrine Span 10 mg.

   f. Respondent failed to indicate in his office records the increase in Dexedrine dose from 10 to 15 milligrams until the office record entry dated April 24, 1990, although Respondent began prescribing the increased dose on January 23, 1990.

   g. Respondent failed to accurately record in his office records the instructions for use he wrote on prescriptions for Patient H in that, in office record entries dated July 2, 1990, August 15, 1990, September 10, 1990, October 15, 1990, December 17, 1990, and January 21, 1991, Respondent recorded "BID" as the instructions for use for the drugs Stelazine and Artane, although the prescriptions for these drugs, dated June 15, 1990, September 24, 1990 and October 15, 1990 indicated "TID" as the instructions for use.

h. Respondent failed to adequately monitor and/or record Patient H's response to pharmacotherapy and/or psychotherapy.

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

I. Respondent provided psychiatric care to Patient I from approximately July 7, 1986 through approximately December 27, 1991. Respondent prescribed drugs for Patient I and recorded Patient I's drug regimen in his office records, as specified in Appendix VI.

1. Respondent prescribed drugs for Patient I at various times from July 7, 1986 through January 2, 1987 without maintaining any records regarding Patient I.

2. Respondent prescribed Triavil and Stelazine for Patient I, which were not indicated and/or without recording the indication.

3. Respondent prescribed Dexedrine for Patient I which was not indicated and/or without recording the indication.

4. Respondent prescribed Ativan, Buspar, Desyrel, Prozac, Stelazine, Tenuate Dospan, Triavil, and Vivactil in combination for Patient I, which was not indicated and/or contraindicated and/or without recording the indication.

5. Respondent, with regard to the evaluation, treatment and/or maintenance of records for Patient I, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals or plans for Patient I.

   b. Respondent failed to adequately monitor and/or record Patient I's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his treatment of Patient I.

   c. Respondent failed to record in his office records that he prescribed Buspar, Desyrel, Dexedrine,

Meprobamate, Symetrel, Vivactil, and/or Xanax for Patient I and/or failed to record the instructions for use and/or indications for such drugs.

d. Respondent failed to record in his office records that he prescribed Triavil 4/25 on January 10, 1987 for Patient I but rather recorded that he prescribed Triavil 4/50.

e. Respondent failed to maintain adequate records for Patient I.

J. Respondent provided psychiatric care to Patient J from approximately January 11, 1983 to at least approximately March 10, 1992. Respondent prescribed drugs for Patient J and recorded Patient J's drug regimen in his office records, as specified in Appendix VII.

1. Respondent prescribed Meprobamate, Dexedrine, and/or Stelazine for Patient J, which were not indicated and/or contraindicted and/or without recording the indications.

2. Respondent, with regard to the evaluation, treatment and/or maintenance of records for Patient J, failed to do the following.

   a. Respondent failed to develop and/or record treatment goals or plans for Patient J.

   b. Respondent failed to adequately monitor and/or record Patient J's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his treatment of Patient J.

   c. Respondent failed to record in his office records that he prescribed Darvocet, Flexeril, Levoxine, Meprobamate, and/or Tenormin for Patient J and/or failed to record the instructions for use and/or indications for such drugs.

   d. Respondent failed to address with Patient J, and/or record that he had done so, Patient J's August 18, 1989 emergency admission to the Erie County Medical Center due to Meprobamate overdose.

e. Respondent failed to maintain adequate records for Patient J.

K. Respondent provided psychiatric care to Patient K from approximately November 28, 1988 through approximately November 8, 1991. Respondent prescribed drugs for Patient K and recorded Patient K's drug regimen in his office records, as specified in Appendix VIII.

1. Respondent prescribed Dexedrine, Xanax and/or Noludar for Patient K which were not indicated and/or contraindicated and/or without recording the indications.

2. Report prescribed Navane and/or Triavil for Patient K which were not indicated and/or without recording the indications.

3. Respondent prescribed Dexedrine, Phenobarbital, Placidyl, Prozac and Xanax for Patient K in combination which was not indicated and/or contraindicated and/or without recording the indications.

4. Respondent, with regard to the evaluation, treatment and/or maintenance of records for Patient K, failed to do the following:

   a. Respondent failed to develop and/or record treatment goals or plans for Patient K.

   b. Respondent failed to adequately monitor and/or record Patient K's response to pharmacotherapy and/or psychotherapy and/or record adequate progress notes of his treatment of Patient K.

   c. Respondent failed to address with Patient K, and/or record that he had done so, the referral by Respondent's office of Patient K, on approximately August 24, 1989 to another physician for refill of medication during which referral Patient K tried to secure addictive drugs.

d. Respondent failed to record in his office records that he prescribed Anafranil, Antabuse, Desyrel, Dilantin, Dolobid, Keflex, Navane, Phenobarbital, and/or Placidyl for Patient K and/or failed to record the instructions for use and/or indications for such drugs.

e. Respondent failed to record in his office record entry dated June 6, 1990 that he prescribed Dexedrine Span 15mg to be taken "2 8 a.m." but rather recorded that the drug be taken "one QD."

f. Respondent failed to record in his office record entry dated December 6, 1990 that he prescribed Dexedrine Span 10mg to be taken "3 8 a.m." but rather recorded that he had prescribed "Dexedrine 15 mg" to be taken "QD."

g. Respondent failed to maintain adequate records for Patient K.

L. Respondent provided psychiatric care to Patient L from approximately 1963 through approximately the spring of 1966 and from approximately the spring of 1968 through approximately January, 1973 at Respondent's office at 765 Wehrle Drive, Buffalo, New York 14225.

1. Respondent, on numerous occasions beginning in approximately October, 1971 through approximately January, 1973, during Patient L's appointments at his office, engaged in sexual intercourse with Patient L.

M. Respondent provided psychiatric care to Patient M from approximately May 5, 1971 through approximately November 23, 1971 at his office at 765 Wehrle Drive, Buffalo, New York 14225.

1. Respondent, on numerous occasions during the period from at least approximately August, 1971 through approximately November, 1971, during Patient M's

appointments at his office, hugged and kissed Patient M in a sexual manner and/or engaged in sexual intercourse with Patient M.

2. Respondent on numerous occasions during the period from at least approximately July, 1971 through at least approximately November, 1971 socialized with Patient M and/or dated Patient M at places other than Respondent's office.

3. Respondent on numerous occasions during the period from at least August, 1971 through at least approximately November, 1971, engaged in sexual intercourse with Patient M at places other than Respondent's office.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

CONDUCT EVIDENCING MORAL UNFITNESS

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

1. The facts in Paragraphs A and A.2 and/or A and A.3.
2. The facts in Paragraphs B and B.2, B and B.3 and/or B and B.4.
3. The facts in Paragraphs C and C.2, C and C.3 and/or C and C.4.
4. The facts in Paragraphs D and D.3.
5. The facts in Paragraphs L and L.1.
6. The facts in Paragraphs M and M.1, M and M.2 and/or M and M.3.

SEVENTH THROUGH TENTH SPECIFICATIONS

WILLFUL PHYSICAL ABUSE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(31) (McKinney Supp. 1992) by reason of his willfully harassing, abusing, or intimidating a patient physically, in that Petitioner charges:

7. The facts in Paragraphs A and A.2 and/or A and A.3.
8. The facts in Paragraphs B and B.2.
9. The facts in Paragraphs C and C.3.
10. The facts in Paragraphs D and D.3.

ELEVENTH THROUGH TWELFTH SPECIFICATIONS

WILLFUL VERBAL ABUSE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(31) (McKinney Supp. 1992) by reason of his willfully harassing, abusing, or intimidating a patient verbally, in that Petitioner charges:

11. The facts in Paragraphs B and B.3, B and B.4, and/or B and B.5.
12. The facts in Paragraphs C and C.2 and/or C and C.4.

THIRTEENTH THROUGH TWENTY-FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

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

13. The facts in Paragraphs A and A.2 and/or A and A.3.

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

15. The facts in Paragraphs C and C.2, C and C.3, and/or C and C.4.

16. The facts in Paragraphs D and D.3, D and D.4, D and D.5, D and D.7, D and D.8, D and D.10(d), and/or D and D.10(g).

17. The facts in Paragraphs E and E.1, E and E.2(a), E and E.2(b), and/or E and E.2(c).

18. The facts in Paragraphs F and F.1, F and F.2, F and F.3(a), F and F.3(b), and/or F and F.3(e).

19. The facts in Paragraphs G and G.2, G and G.3(e), G and G.3(f), and/or G and G.3(g).

20. The facts in Paragraphs H and H.1, H and H.2, H and H.3(b), H and H.3(h), and/or H and H.3(i).

21. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5(b), I and I.5(c), and/or I and I.5(e).

22. The facts in Paragraphs J and J.1, J and J.2(b), J and J.2(c), and/or J and J.2(e).

23. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4(b), K and K.4(d), and/or K and K.4(g).

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

25. The facts in Paragraphs M and M.1, M and M.2 and/or M and M.3, insofar as they occurred on or after September 1, 1971.

TWENTY-SIXTH THROUGH THIRTY-SIXTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

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

26. The facts in Paragraphs A and A.2 and/or A and A.3.

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

28. The facts in Paragraphs C and C.2, C and C.3, and/or C and C.4.

29. The facts in Paragraphs D and D.3, D and D.4, D and D.5, D and D.7, D and D.8, D and D.10(d), and/or D and D.10(g).

30. The facts in Paragraphs E and E.1, E and E.2(a), E and E.2(b), and/or E and E.2(c).

31. The facts in Paragraphs F and F.1, F and F.2, F and F.3(a), F and F.3(b) and/or F and F.3(e).

32. The facts in Paragraphs G and G.2, G and G.3(e), G and G.3(f), and/or G and G.3(g).

33. The facts in Paragraphs H and H.1, H and H.2, H and H.3(b), H and H.3(h), and/or H and H.3(i).

34. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5(b), I and I.5(c), and/or I and I.5(e).

35. The facts in Paragraphs J and J.1, J and J.2(b), J and J.2(c), and/or J and J.2(e).

36. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4(b), K and K.4(d), and/or K and K.4(g).

THIRTY-SEVENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

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

THIRTY-EIGHTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) (McKinney Supp. 1992) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

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

THIRTY-NINTH THROUGH FORTY-NINTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1992) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

39. The facts in Paragraphs A and A.4(a), A and A.4(b), A and A.4(c), and/or A and A.4(d).

40. The facts in Paragraphs B and B.6(a), B and B.6(b), and/or B and B.6(c).

41. The facts in Paragraphs C and C.5(a), C and C.5(b), C and C.5(c), and/or C and C.5(d).

42. The facts in Paragraphs D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10(a), D and D.10(b), D and D.10(c), D and D.10(d), D and D.10(e), D and D.10(f), and/or D and D.10(g).

43. The facts in Paragraphs E and E.1, E and E.2(a), E and E.2(b), and/or E and E.2(c).

44. The facts in Paragraphs F and F.2, F and F.3(a), F and F.3(b), F and F.3(c), F and F.3(d) and/or F and F.3(e).

45. The facts in Paragraphs G and G.1, G and G.2, G and G.3(a), G and G.3(c), G and G.3(d), G and G.3(e), G and G.3(f) and/or G and G.3(g).

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

47. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5(a), I and I.5(b), I and I.5(c), I and I.5(d), and/or I and I.5(e).

48. The facts in Paragraphs J and J.1, J and J.2(a), J and J.2(b), J and J.2(c), J and J.2(d), and/or J and J.2(e).

49. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4(a), K and K.4(b), K and K.4(c), K and K.4(d), K and K.4(e), K and K.4(f) and/or K and K.4(g).

DATED: Albany, New York
June 16, 1992

Peter D. Van Buren

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