Effe Date 3/22/90

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

January 24, 1990

Libardo Rojas, Physician
50 Lake Avenue
Blasdell, N.Y. 14219

Re: License No. 089407

Dear Dr. Rojas:

Enclosed please find Commissioner's Order No. 10231. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Peter A. Vinolus, Esq.
609 Ridge Road
Lakawana, N.Y. 14218

REPORT OF THE
REGENTS REVIEW COMMITTEE

LIBARDO ROJAS

CALENDAR NO. 10101

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

LIBARDO ROJAS **No. 10231**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

LIBARDO ROJAS, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on October 25 and December 19, 1988, and January 4, January 5, January 9, and February 13, 1989 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of

the first through eleventh specifications of the charges to the extent indicated by the hearing committee, and thirteenth specification of the charges to the extent indicated by the hearing committee, and not guilty of the twelfth specification of the charges.

The hearing committee recommended that respondent's license to practice as a physician in the State of New York be revoked and that he never be allowed to practice medicine in this state or any other again.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted and that the recommendation of the hearing committee be accepted except to the extent that the hearing committee recommended that respondent never be allowed to practice in New York or elsewhere. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 2, 1989 respondent appeared before us in person and was represented by his attorney, Peter A. Vinolus, Esq., who presented oral arugment on behalf of respondent. Cindy M. Fascia, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of

discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be revoked.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was probation.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's October 18, 1989 letter and attached submissions, respondent's two character reference letters dated October 26, 1989, and petitioner's November 1, 1989 letter. We note that we ruled that all these submissions were accepted into the record in the nature of briefs, memoranda of law, and character references and not as new evidence in this case.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact and conclusions as to the question of respondent's guilt, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted; and
2. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges based on willful physical abuse and willful physical harassment of a patient, the second specification of the

charges based on willful physical harassment and willful verbal harassment of a patient, the third specification of the charges based on willful physical abuse of a patient, the fourth specifiction of the charges based on willful physical abuse and willful verbal abuse of a patient, the fifth specification of the charges based on willful physical abuse and willful verbal abuse of a patient to the extent indicated in the hearing committee report, the sixth specification of the charges based on willful physical abuse of a patient, the seventh specification of the charges to the extent indicated in the hearing committee report, the eighth through eleventh specifications of the charges, and the thirteenth specification of the charges, and not guilty of the twelfth specification of the charges.

By a vote of two to one, the undersigned and Patrick J. Picariello, Esq., recommend the following to the Board of Regents:

3. The hearing committee's recommendation as to the measure of discipline be accepted to the extent indicated by the Commissioner of Health, and the Commissioner of Health's recommendation as to the measure of discipline be accepted; and

4. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of

the charges of which we recommend respondent be found guilty. Respondent may, pursuant to Rule 24.7(b) of the Rules of the Board of Regents, apply for restoration of said license after one year has elapsed from the effective date of the service of the order of the Commissioner of Education to be issued herein; but said application shall not be granted automatically.

Jane M. Bolin, Esq., dissents as to the measure of discipline and, in that regard, recommends the following to the Board of Regents as being sufficient under all the circumstances herein:

That the hearing committee's and Commissioner of Health's recommendations as to the measure of discipline not be accepted; and

That respondent's license to practice as a physician in the State of New York be suspended for one year and respondent be required to perform 100 hours of public service upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently and said public service to total 100 hours and be served concurrently, and that execution of the last ten months of said suspensions be stayed at which time respondent then be placed on probation for said last ten months under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

LIBARDO ROJAS (10231)

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: December 14, 1989

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

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IN THE MATTER : STATEMENT

OF : OF

LIBARDO ROJAS, M.D. : CHARGES

----------X

LIBARDO ROJAS, M.D., the Respondent, was authorized to practice medicine in New York Sate on September 10, 1962 by the issuance of license number 089407 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 50 Lake Avenue, Blasdell, New York 14219.

FACTUAL ALLEGATIONS

A. Respondent employed Individual A (identified in th Appendix) to work one evening per week at Respondent's medical office at 50 Lake Avenue, Blasdell, New York (hereinafter "Respondent's office"). Individual A was so employed by Respondent from on or about February 11, 1988, to March 24, 1988 when Individual A terminated her employment.

1. Respondent, during the course of Individual A's employment on or about March 17, 1988:

EXHIBIT "A"

(i) traced with his finger the outline of Individual A's panties, and asked her why she wore the type of panties tha she did.

(ii) told Individual A that when a woman is raped, she migh fight at first, but ends up enjoying it.

2. Respondent, during the course of Individual A's employment on or about March 24, 1988, made comments of a sexual nature to Individual A, in that:

(i) Respondent asked Individual A how many times a week she had sex, and said that he thought that she was "hot".

(ii) Respondent told Individual A that a woman burns up a lot of calories during sex.

3. Respondent, during the course of Individual A's employment on or about March 24, 1988, made comments regarding Individual A's physical appearance, and inappropriately touched Individual A, in that:

(i) Respondent told Individual A to step on the scale in his office, asked her what her measurements were, measured her bust over her shirt with a tape measure, pulled her shirt up and measured her bust again underneath her clothing, and measured her waist and hips.

(ii) Respondent sat on the arm of the chair in which Individual A was sitting, and while he played with her hair asked her if she colored her hair, told her that she smelle good, and asked her what kind of perfume she was wearing.

4. Respondent, during the course of Individual A's employment on or about March 24, 1988, made sexual advances to Individual A, and forced physical sexual contact upon her, in that:

(i) Respondent pushed Individual A's head down and kisse her neck, while putting his hand up the back of her shirt.

(ii) Respondent tried to force Individual A's legs apart.

(iii) Respondent pulled Individual A's face towards him an kissed her on the mouth.

(iv) Respondent pulled Individual A's body against his an moved his pelvis against her.

(v) Respondent bit Individual A's shoulder, causing her pain, and told her that he wanted to hear her scream.

(vi) Respondent grabbed Individual A's arms and tried to pull her against him as she tried to push him away.

(vii) Respondent grabbed the arm of Individual A's coat as she was putting it on, and tried to prevent her from puttir on her coat.

B. Respondent, on or about November 19, 1977, treate Patient B (Patients are identified in the Appendix) at Our Lady of Victory Hospital in Lackawanna, New York (hereinafter "Our Lac of Victory Hospital"), for a lacerated thumb. Thereafter, Respondent, during November and December 1977, provided follow-u care to Patient B at Respondent's office.

1. Respondent, during the course of appointments on c about November 22, 1977, November 29, 1977, and December 8, 1977 repeatedly commented on Patient B's physical attractiveness, her hair color and other aspects of her appearance, and told her she was beautiful.

2. Respondent, during the course of an appointment or or about December 15, 1977, directed Patient B to step on the scale in his office. Thereafter, Respondent:

(i) told Patient B that she had a nice figure.

(ii) gestured around Patient B's hips and told her that sh "could use a little less there".

(iii) put his hands under Patient B's breasts and told her that she "could use a little more there".

C. Respondent, on or about June 26, 1978, at Our Lad of Victory Hospital, removed a ganglion cyst from Patient C's right wrist. Thereafter, Respondent, on several occasions durin June, July and August 1978, provided follow-up care to Patient C at Respondent's office.

1. Respondent, during the course of appointments on c about July 10, 1978, July 18, 1978, July 24, 1978, and July 31, 1978:

(i) commented on Patient C's physical beauty.

(ii) asked Patient C to go on dates with him.

(iii) tried to kiss Patient C's neck.

2. Respondent, during the course of an appointment or or about August 11, 1978, directed Patient C to ~~remove~~ UNBUTTON her blous and checked her heartbeat. Thereafter, Respondent grabbed Patien C's breast and told her they should, "make love, not war".

D. Respondent, on or about March 30, 1983, saw Patien D at the New York State Employee Health Service at 65 Court Street Buffalo, New York. (hereinafter NYS Employee Health Service) for evaluation of a back injury. During the course of this

appointment, Respondent placed his hand inside Patient D's examining gown and grabbed her right breast.

E. Respondent, on or about July 15, 1982, saw Patien E at the NYS Employee Health Service for evaluation of a back injury. During the course of this appointment:

1. Respondent, while looking at the bottoms of Patier E's feet, told her that anyone with callouses on their feet was out "romping around" and was not injured.

2. Respondent, while looking at Patient E's fingernails, told her that since her fingernails were bitte she must be nervous about all the lies she was telling.

3. Respondent told Patient E that since she could not remember the exact date of her injury the injury must be insignificant.

4. Respondent accused Patient E of being an alcoholic

5. Respondent grabbed Patient E's left breast and twisted it, causing her pain.

6. Respondent accused Patient E of feigning injury, ar told her that the only thing wrong with her was probably a "social disease".

F. Respondent, on or about March 30, 1983, saw Patier F at the NYS Employee Health Service for evaluation of injuries to her back and neck. During the course of this appointment:

1. Respondent, before examining Patient F, told her that it was "ridiculous" that she was out of work when she "didn't even have a broken bone".

2. Respondent directed Patient F to sit on a stool wit wheels which was against a wall. Patient F moved the stool away from the wall, and as she was lowering herself onto th stool, Respondent slammed the stool back against the wall, exposing Patient F to the risk of falling.

3. Respondent, during his examination of Patient F, turned and twisted her head and neck back and forth in a roug and rapid manner. Respondent continued to do this despite Patient F's complaints of pain and pleas for him to stop.

G. Respondent, on or about May 19, 1982, saw Patient G at the NYS Employee Health Service for evaluation of a back injury. During the course of this appointment:

1. Respondent directed Patient G to lie on her back o an examining table, and pulled the examining gown she was wearing over her head and face.

2. Respondent fondled Patient G's breasts.

3. Respondent took a safety pin and raked it down Patient G's right leg from thigh to foot, causing bleeding.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

HARASSING, ABUSING OR INTIMIDATING A PATIENT

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) and 8 NYCRR §29.2(a)(2) (1987) by his willfully harassing, abusing or intimidating a patient either physically or verbally, in that the State Board for Professional Medical Conduct (hereinafter Petitioner) alleges:

1. The facts in paragraph B and B.1, and/or B.2(i), and/or B.2(ii), and/or B.2(iii).
2. The facts in paragraph C and C.1(i), and/or C.1(ii), and/or C.1(iii), and/or C.2.
3. The facts in paragraph D.
4. The facts in paragraph E and E.1, and/or E.2, and/or E.3, and/or E.4, and/or E.5 and/or E.6.
5. The facts in paragraph F and F.1, and/or F.2, and/or F.3.
6. The facts in paragraph G and G.1, and/or G.2, and/or G.3.

SEVENTH THROUGH THIRTEENTH SPECIFICATIONS

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney

1985) and 8 NYCRR §29.1(b)(5) (1987) by his conduct in the practice of the profession which evidences moral unfitness to practice the profession, in that Petitioner alleges:

7. The facts in paragraph A and A.1(i), and/or A.1(ii), and/or A.2(i), and/or A.2(ii), and/or A.3(i), and/or A.3(ii), and/or A.4(i), and/or A.4(ii), and/or A.4(iii) and/or A.4(iv), and/or A.4(v), and/or A.4(vi), and/or A.4(vii), and/or A.4(viii).

8. The facts in paragraph B and B.1 and/or B.2(ii) and/or B.2(iii).

9. The facts in paragraph C and C.1.(i), and/or C(1)(ii) and/or C(1)(iii), and/or C.2.

10. The facts in paragraph D.

11. The facts in paragraph E and E.1, and/or E.2, and/or E.3, and/or E.4, and/or E.5, and/or E.6.

12. The facts in paragraph F and F.1, and/or F.2, and/or F.3.

13. The facts in paragraph G and G.1, and/or G.2, and/or G.3.

DATED: Albany, New York
September 20, 1988

Peter D. Van Buren

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

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

IN THE MATTER :

OF : HEARING COMMITTEE REPORT

LIBARDO ROJAS, M.D. :

TO: THE HONORABLE DAVID AXELROD, M.D.
Commissioner of Health, State of New York

The undersigned Hearing Committee (the Committee) consisting of Ann Shamberger, Chairperson, Glenda D. Donoghue M.D. and Therese G. Lynch, M.D. was duly designated and appointed by the State Board for Professional Medical Conduct (the Board) Jonathan M. Brandes, Administrative Law Judge served as Administrative Officer.

The hearing was conducted pursuant to the provisions of New York Public Health Law Section 230 and New York State Administrative Procedure Act Sections 301-307 to receive evidence concerning the charges that Respondent has violated provisions of New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made part of the record.

The Committee has considered the entire record in the above-captioned matter and makes this Report of its Findings, Conclusions and Recommendation to the New York State Commissioner of Health.

I. RECORD OF PROCEEDINGS

Statement of Charges dated:	September 20, 1988
Notice of Hearing returnable:	October 25, 1988
Place of Hearing:	Cheektowaga, NY
Respondent served with copy of Notice of Hearing and Charges:	September 29, 1988
The State Board for Professional Medical Conduct appeared by:	Cindy M. Fascia Associate Counsel Office for Professional Medical Conduct Corning Tower Building Albany, NY 12237
The Respondent appeared in person and was represented by:	Peter A. Vinolus, Esq. 609 Ridge Road Lackawana, NY 14218
Respondent's present address:	50 Lake Avenue Blasdell, NY 14219
Pre-hearing Conference held:	October 24, 1988
Hearings held on:	October 25, 1988 December 19, 1988 January 4, 5, 9, 1989 February 13, 1989
Record closed:	April 6, 1989
Deliberations held:	April 21, 1989

II. SUMMARY OF PROCEEDINGS

1. The Statement of Charges alleges that Respondent has committed acts which evidence moral unfitness to practice medicine and harassed, abused and/or intimidated a patient. The allegations arise from an alleged incident with an employee as well as alleged incidents with six patients. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

2. The Petitioner called these witnesses:

Individual A	Fact witnesses
Patients B through G	Fact witnesses

3. The Respondent testified in his own behalf and called those witnesses:

Vera Pulera	OPMC Investigator; Fact witness
Robert Haenszel	Director, Institution Resource Management, J.N. Adam Developmental Center; Fact witness
Gloria McKnight	Respondent's former employee; fact/character witness
Barbara J. Christy	Personnel Associate, SUNY Buffalo; fact witness
Thomas Shea	Personnel Employee West Seneca Developmental Center; fact witness

FINDINGS OF FACT WITH REGARD TO INDIVIDUAL A

1. Individual A was employed as a part-time secretary/receptionist at Respondent's office at 50 Lake Avenue, Blasdell, New York. Her regular working hours were Thursday nights from 6 o'clock to 10 o'clock p.m. (T. 165-167)

2. Individual A agreed to take the position at Respondent's office as a favor to a friend of her family, who had worked for Respondent. Individual A had never met Respondent prior to beginning her employment at his office. (T. 165-67)

3. Individual A worked for Respondent for a total of seven occasions; February 11, 1988; February 18, 1988; February 25, 1988; March 3, 1988; March 10, 1988; March 17, 1988; and March 24, 1988. (T. 170)

4. On the evenings that she worked for Respondent, Individual A was the only staff person in the office. (T. 269)

5. Respondent's practice on Thursday evenings was always to schedule all the patients for 8 o'clock. The patients would then be seen on a "first come, first served" basis. (T. 270, T. 169)

6. Prior to March 17, 1988, on the occasions Individual A worked at Respondent's office, he repeatedly commented on her physical appearance, which made Individual A uncomfortable. (T. 173-174)

7. On March 17, 1988, after all the patients had left the office, Respondent commenced a conversation with Individual A. During the course of that conversation, Respondent told

Individual A that when a woman is raped, she might fight at first, but ends up enjoying it. (T. 175) This conversation took place before 10 o'clock, during Individual A's working hours. (T. 176-177)

8. On March 17, 1988, after all the patients had left and Respondent and Individual A were alone in the office, Respondent traced, with his finger on her buttocks, the outline of Individual A's underpants through her trousers, and asked her why she wore the type of underpants that she did. (T. 177-178)

9. Following the events of March 17, 1988, Individual A did not want to return to work at Respondent's office. After talking with her husband and her mother, she decided to go back because she had taken the job as a favor to her family's friend. (T. 179, T. 236).

10. On March 24, 1988, after all the patients were gone and Respondent and Individual A were alone in the building, Respondent called Individual A back into his private office, and a conversation ensued between them. (T. 182-184, T. 242)

11. During the course of this conversation, Respondent told Individual A that she had a nice figure. When Individual A said that she should lose weight, Respondent told her that a woman burns up a lot of calories during sex. (T. 196)

12. Respondent, on March 24, 1988, said to Individual A "I bet you're hot, how many times do you have sexual intercourse in a week, I bet you're hot... ." (T. 196)

13. Respondent told Individual A to step on the scale in his office, asked her what her measurements were, measured her hips, waist, and bust over her clothing with a tape measure. He admits he then pulled up her sweater and measured her bust again under her sweater but over her brassiere. (T. 186, T. 188-189, 935)

14. Individual A walked away from the scale and sat in the chair in Respondent's office. Respondent sat on the arm of the chair and began to play with Individual A's hair, asked her if she colored her hair, told her she smelled good, and asked her what kind of perfume she was wearing. (T. 190-191)

15. Respondent, while he was sitting on the arm of the chair, pushed Individual A's head down and kissed her neck. As he held her down with one hand, he began to put his other hand up the back of her shirt. (T. 191-192, T. 248)

16. When Individual A pushed herself back up to a sitting position, Respondent got in front of her and began trying to get himself between her legs. While Individual A kept holding her legs closed, and kept telling Respondent to stop, Respondent tried to pull Individual A's legs apart by using his hands to force them apart. (T. 192-193, T. 247-249)

17. Respondent put his hands on each side of Individual A's face, pulled her head and face forward toward him. He kissed her on her mouth. Respondent admits kissing Individual A's face and lips. (T. 193, T. 250, 917, 938)

18. Individual A pushed Respondent back and stood up out of the chair. Respondent then pulled Individual A toward his desk, held her against him, and rubbed his body against her. (T. 193-194, T. 196, T. 255-256)

19. While Respondent was pulling Individual A against him and rubbing himself against her, Individual A tried to push him away. (T. 193-194, T. 255-266)

20. Respondent bit Individual A on her right shoulder, near her clavicle, causing her pain, and told her that he bit her because he wanted to hear her scream. (T. 193-194)

21. Individual A pushed herself away from Respondent, and told him that she was leaving. She went into the reception area to get her coat. As Individual A was putting on her coat, Respondent took hold of her coat, saying he would help her. Individual A could not get her arm into the coat, and she grabbed her coat away, saying she would do it herself. (T. 195, T. 250-251)

22. Individual A went home. She found her husband had gone to his aunt's house. She followed him there. She told her husband and his aunt that same night what Respondent had done to her. (T. 199-202)

23. On the day after the incident, March 25, 1988, Individual A told her mother what had happened. She also told a close friend, who put Individual A in touch with a rape crisis volunteer. Individual A told the rape crisis volunteer what had happened, and that woman gave Individual A the phone number and a

contact person at the Erie County Sheriff's Department. (T. 217, T. 203)

24. Individual A telephoned the Erie County Sheriff's Department on March 25, 1988. She spoke to the person on call there, and was told that she would be contacted as to when she could come down to the Sheriff's office in person to talk to someone. She was subsequently contacted and went to the Sheriff's office on march 30, 1988, where she made a sworn written statement to the police concerning Respondent's actions of March 17 and March 24, 1988. (T. 203-204; T. 223-226)

25. Individual A never returned to Respondent's office after March 24, 1988. She terminated her employment by leaving a message with Respondent's answering service that she would no longer be coming into work on Thursday evenings, and that Respondent would know why. (T. 205)

CONCLUSIONS WITH REGARD TO INDIVIDUAL A AND SPECIFICATION SEVEN

In assessing the first set of allegations which concern Individual A the committee was asked to consider whether allegations A.1 through A.4 occurred and, if they did occur, whether they constituted acts evidencing moral unfitness to practice medicine. At the times these acts allegedly occurred there were but two persons present in Respondent's office; Respondent and the alleged victim. This situation of isolation goes to the heart of the charges on two levels. First, to sustain the factual allegations, the Committee must choose to believe

either Respondent or the alleged victim. Secondly to sustain the specifications the Committee must find that Respondent's acts constituted a breach of trust conferred upon him by virtue of his licensure; that Individual A would not have placed herself in the compromising position of being alone with an older man who was basically a stranger but for the fact that this stranger was a member of an esteemed professional community and there was an employment relationship between them.

As to the issue of credibility, the Committee was unanimous that Individual A was entirely credible and that the acts alleged (except for A.4(vii)) did in fact occur. In so finding the Committee concludes Individual A established an extremely high level of candor and truthfulness. She was straight forward and direct in her answers. She did not become defensive during cross examination but rather seemed to be expending great effort to provide accurate answers, correcting both counsel for the State and the defense when she disagreed with a contention. This individual was forthright and was noted to meet the panel's gaze with direct eye contact despite the fact that she could not know whether the members were sympathetic or saw her account as a fabrication.

Individual A presented herself as a young, (22 years of age as of the date of testimony; 21 on the date of the incident) married woman given to conservative behavior, easily embarrassed and generally shy. She was well beyond the age and maturity level where she would continue to assert the claims herein if she were

caught in a fabrication. In fact, the Committee finds Individual A presented a logical whole in her account. The Committee notes that on March 17 Respondent engaged in highly suggestive activity but it was not incredible that Individual A returned March 24 given three factors: Respondent was an older professional; Individual A had been referred to the job by a family friend and a young woman in such a situation, while admittedly nervous will typically deny that anything untoward has happened or will happen. The subsequent actions by Individual A, after the events of March 24, affirm her credibility. She wanted to tell her husband; he was not home. She did not wait for him to return but sought him out. She also filed a report with the Erie County Sheriff. Finally, she never went back to Respondent's office even to return Respondent's key. While there were some minor questions left unresolved regarding the precise sequence of events on March 24, the Committee finds such certitude unnecessary to believe the events actually occurred whatever their exact order.

Against Individual A's very strong credibility must be assessed Respondent's presentation. The Committee finds Respondent, while denying any overt sexual or suggestive actions, basically alleged he was seduced by Individual A and that any man in his situation would have acted similarly. Respondent admits kissing Individual A but "as a father" although "on the lips" (T. 938-9). He also admitted measuring her bust under her sweater (T. 935). The Committee finds the acts admitted entirely unacceptable. Where Respondent kissed individual A is irrelevant.

That he indeed kissed her and admitted to further physical contact of an intimate nature under the circumstances herein cannot be tolerated. Respondent was an older professional alone in his office with a younger married woman late in the evening. He cannot be said to have attained any level of familiarity with this woman whom he had known but a few hours. He therefore had no legitimate basis for any form of close contact. Indeed, the entire scenario postulated by Respondent, that Individual A overtly or intentionally encouraged intimacy between them, erodes Respondent's position as to the quality of his judgment and certainly as to his willingness to tell the truth. Given Individual A's guileless presentation, in comparison to Respondent's clear mendacity, the Committee believes Individual A's account of March 17 and 24, 1988.

Accordingly allegations A.1(i) through A.4(vi) are unanimously sustained without further comment. Allegation A.4(iv) (that Respondent rubbed his pelvis on Individual A) is sustained but the Committee notes that they believe Respondent rubbed his body against Individual A and finds it irrelevant what area of his body he rubbed against her. The Committee unanimously does not sustain allegation A.4(vii) finding insufficient proof that respondent tried to prevent individual A from leaving (T. 195)

With regard to Specification Seven, the Committee first notes that allegation A.4(viii) is charged but does not exist. In assessing the extant charges the Committee was instructed that conduct in the practice of the profession which evidences moral

unfitness to practice the profession entails two standards: to sustain a violation of 8 NYCRR 29.1(b)(5) the Committee must find Respondent violated a trust conferred upon him by virtue of his licensure. In addition or in the alternative, the Committee could find a violation if they found Respondent's acts could be shown to have violated the moral standards of the professional community which the Committee represents.

The Committee was unanimous in its finding that Respondent had significantly violated both standards. Respondent had violated a trust conferred upon him by sole virtue of his licensure in that Individual A would not have tolerated being measured under her sweater but for the fact that Respondent was a licensed physician. Indeed it could be said Individual A would not have returned to the situation of isolation she found herself in on March 24, given the highly suggestive events of March 17 but for Respondent's position in the community as a licensed physician. In like fashion the Committee finds Respondent's acts herein violated the moral standards of the professional community. Employees have a right to expect greater discretion on the part of physicians. The standard of the professional community of this State allows young women to work alone in an office with a male physician at night without fear of being accosted. Respondent's actions constitute an egregious violation of those standards.

SPECIFICATION SEVEN IS UNANIMOUSLY SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Patient B was initially treated by Respondent at Our Lady of Victory Hospital on November 19, 1977. Patient B had come to the emergency room for treatment of her severely lacerated thumb. The emergency room staff referred her to Respondent, who performed emergency surgery on Patient B. (T. 75-76; Ex. 4)

2. Following the surgery at Our Lady of Victory Hospital, Patient B saw Respondent for follow-up care at his office at 50 Lake Avenue, Blasdell, New York. She saw Respondent on four occasions. These appointments were on November 22, November 29, December 8 and December 15, 1977. (Petitioner's Exhibit 4)

3. At the time she was seeing Respondent as a patient, Patient B had her own personal family physician and obstetrician/gynecologist. She was seeing Respondent solely for follow-up care related to her thumb. (T. 77, 81, 84-86)

4. During the course of Patient B's appointments on November 22, November 29, and December 8, 1977, Respondent repeatedly commented on Patient B's physical attractiveness, her hair color and other aspects of her physical appearance. (T. 82-83, T. 117, 122-23, 151)

5. Patient B was initially not troubled by these comments. However, the remarks were constant and continuous and she began to be uncomfortable and uneasy. Receiving compliments usually does not make her uncomfortable. (T. 117, 122-23, 151)

6. During Patient B's office visits with Respondent, there was a nurse in the outer office but no nurse present in the room where he examined her. Patient B would be alone in the room with Respondent. The door to this room was always closed. (T. 82, T. 86-87)

7. On December 15, 1977, Patient B again went to Respondent's office for treatment. As usual, the door to the room where the examination took place was closed. Respondent and Patient B were alone. Respondent on this occasion again made flattering remarks and comments about Patient B's appearance. Respondent asked Patient B how much she weighed, and she replied that she did not know. Respondent then told Patient B to get on the scale in his office, which she did. (T. 87-88)

8. Respondent told Patient B that her weight was perfect. Patient B stepped off the scale. Respondent then told Patient B that she "could use a little less here," while he gestured with his hands around her hips, without touching her. Respondent then put his hands under Patient B's breasts, lifted her breasts, and told her that she "could use a little more there."

9. Patient B walked out of the Respondent's office. As she walked through the reception area, the nurse asked if she needed another appointment. Patient B replied, "Not here, I don't," and told the nurse what Respondent had just done to her. (T. 90)

10. Patient B never returned to Respondent's office after the December 15 visit. (T. 92; Petitioner's Ex. 4)

11. Approximately one week after the incidents of December 15, Patient B told her brother-in-law, who was also her employer, about Respondent's conduct. She also told her husband. On January 20, 1978, approximately one month after her last visit to Respondent's office, Patient B and her husband wrote a letter to the Erie County Medical Society about Respondent's conduct. (T. '95, T. 133-34)

CONCLUSIONS WITH REGARD TO PATIENT B AND SPECIFICATIONS ONE AND EIGHT

Patient B was the first patient to be produced by the State. Respondent is charged both with conduct evidencing moral unfitness and with harassing abusing or intimidating a patient (note that the first allegations involved an employee not a patient). Again, as with the first set of allegations, Respondent was alone with a female person, behind a closed door. Again, as in the prior allegations, the accusations stand or fall based upon the credibility of the only two participants in the event, Respondent and Patient B.

Here, as before, the Committee finds the patient entirely credible and Respondent unworthy of belief. Patient B was straightforward and forthcoming in her answers to questions from both sides. Her presentation was balanced and without exaggeration. Patient B was consistent and showed care in distinguishing between what she could and could not remember.

The Committee rejects Respondent's argument that these allegations arise from Patient B's former husband who was a jealous alcoholic with whom she was having marital difficulties. Patient B was candid about her past marital difficulties. She was not reluctant to disclose she had divorced her then husband. Furthermore, the credible evidence shows Patient B immediately reported Respondent's actions to the nurse on duty and within a week told her brother-in-law who was also her employer. These facts vitiate and make incredible Respondent's assertions. Accordingly factual allegations B.1 and B.2(i) through (iii) are unanimously sustained.

With regard to specification one, the Committee was instructed that they were to apply the ordinary meanings to the terms harass, abuse or intimidate in assessing whether a violation of 8 NYCRR 29.2(a)(2) had been established. Thus instructed, the Committee found unanimously that Respondent had harassed and abused this patient by turning his professional privilege, that of being alone in a private place with a woman to whom he was basically a stranger, to his own personal gratification through contact of a non-medical nature. Indeed Patient B had presented herself solely for medical treatment. Her presentation was violated by Respondent's gratuitous and inappropriate physical contact. For the same reasons, and utilizing the previously described definitions, the Committee unanimously sustains Specification Eight finding it is both a violation of the public trust placed upon Respondent by virtue of his licensure and a

violation of community standards for Respondent to have engaged in such gratuitous non-medical physical contact.

SPECIFICATIONS ONE AND EIGHT ARE UNANIMOUSLY SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. Patient C began medical treatment with Respondent because her parents had been seeing him as their general practitioner. (T. 404)

2. On June 26, 1978, Respondent performed surgery on Patient C at Our Lady of Victory Hospital. The surgery consisted of the removal of a ganglion cyst from Patient C's right wrist. Thereafter, on several occasions during that summer, Patient C went to Respondent's office in Blasdell for follow-up care for her wrist. (T. 335, Petitioner's Exhibit 5)

3. During the course of her visits to his office for medical care, Respondent told her that she was beautiful, asked her out on a date with him, and tried to kiss her neck. (Petitioner's Exhibit 5A)

4. Patient C's last visit to Respondent's office was on August 11, 1978. (Petitioner's Exhibit 5). Respondent and Patient C were alone in the room, and the door was closed. (T. 338) Respondent treated Patient C's wrist, as he had done on previous visits. He then told Patient C that he had to listen to her heart. He told her that she had to unbutton her blouse so that he could hear it properly. Respondent listened to Patient C's heart with a stethoscope. He then reached out with his right hand

and took hold of Patient C's left breast with his hand. Patient C had her brassiere on. Respondent then said to Patient C that they should "make love, not war." Patient C buttoned her blouse and walked out of Respondent's office. (T. 336, 339, 378-382)

5. Patient C never returned to Respondent's office after the August 11, 1978 visit. (T. 337, Petitioner's Exhibit 5).

6. Prior to her last appointment with Respondent, Patient C had had breast examinations from other physicians, and had performed breast examinations on herself. The manner in which Respondent touched her breast was different. (T. 338-339).

7. Approximately one week after her last visit to Respondent's office, Patient C wrote a letter to the Erie County Medical Society regarding Respondent's conduct. (T. 340, Petitioner's Exhibit 5A)

8. Approximately one month after her last visit to Respondent's office, Patient C told her parents about Respondent's conduct. (T. 339-340)

9. After she had written to the Erie County Medical Society, Patient C received a phone call from Respondent while she was at work. Respondent told Patient C that he knew about her letter to the Medical Society, and that if she did not want to make love, they could make war. (T. 359)

CONCLUSIONS WITH REGARD TO PATIENT C AND SPECIFICATIONS TWO AND NINE

This witness could not specifically remember many of the factual assertions associated with her. However, she did, at the time in question, write a letter to the Erie County Medical Society describing the events complained of which was received in evidence as past recollection recorded. The Committee finds Patient C entirely credible for many of the reasons cited with earlier witnesses: she was forthright, consistent and careful to distinguish between what she could and could not remember. Her statements were balanced and not exaggerated. At one point she asked the Prosecutor to amend a charge from removal of her blouse to unbuttoning. This quest for accuracy speaks very highly of Patient C's credibility. Moreover, the Committee finds her admission that she could not specifically remember many of the details of her assertions strongly bolsters her credibility. As for the letter itself, it was written approximately a week after the events in question. The Committee based upon Patient C's testimony finds it an accurate and complete description of what took place. While Patient C did not follow-up upon her complaint to the Medical Society when invited to do so, the Committee does not find this in any way dispositive of her credibility, particularly given her willingness to come forward at this time.

The Committee finds Respondent's assertion that the contact in question was a breast examination devoid of credibility. The contact in question bore no resemblance to any

medical procedure and was actually a gratuitous non-medical contact.

Accordingly, the Committee finds allegations C.1(i), (ii) and (iii) and C.2 to be sustained.

With regard to specifications two and nine, the Committee finds Respondent's words on two occasions that he and this patient should "make love, not war" and the circumstances under which they were said to constitute initially an illicit suggestion and subsequently a threat to this patient and therefore harassment. The Committee finds Respondent's conduct in this matter to represent a clear violation of both standards of moral unfitness in that the gratuitous and non-medical contact betrayed this patient's trust and violated the moral standards of the community.

SPECIFICATIONS TWO AND NINE ARE UNANIMOUSLY SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT D

1. Patient D is a motor vehicle operator employed by the State University of New York at Buffalo (Amherst). She has been employed there for ten years. During the course of her employment, she sustained a back injury. Patient D had a reaction to medication prescribed for that injury, with resultant further physical effects. (Petitioner's Exhibit 6, T. 279-281)

2. Patient D's injury occurred on December 21, 1982. Her injury and the symptoms she developed in her extremities

caused her to be temporarily disabled for her employment. (Petitioner's Exhibit 6)

3. Patient D received a letter from her employer telling her that she had to be examined at the New York State Employee Health Service to determine if she was able to return to work. Patient D was anxious to get back to work because she was bored and wanted to resume her normal activities. (T. 283-284)

4. Patient D reported to the Employee Health Service on March 31, 1983. She went to the reception area and was told by the nurse to go to the changing area, to remove all her clothing and to put on a paper gown and paper slippers. She waited in the room where she undressed until she was called into the examining room. No one was present in the examining room other than Respondent and Patient D. (T. 285, Ex. 6)

5. While Patient D was sitting in an upright position on the examination table, Respondent slipped his hand under Patient D's examining gown and took hold of her breast with his hand. (T. 285, 290)

6. Patient D, prior to her visit to the Employee Health Service had had breast examinations by other physicians and had performed self-examination of her breasts. Respondent's touching of her breast was different. (T. 286-289)

7. Respondent said nothing about a breast examination to Patient D before he slipped his hand under her robe and made contact with her breast with his hand. (T. 287)

8. Patient D pushed Respondent's hand away and told him that she was not there for a breast examination. Patient D did not think, however, that what Respondent had been doing was a breast examination. (T. 287)

9. Respondent walked away without looking at Patient D, and kept his back turned to her while he stood at a table in another part of the examining room. He said nothing to Patient D, who finally asked if she was through there. Patient D got down from the examining table, went to get dressed, and left. (T. 286)

10. Patient D had an appointment with her personal physician shortly after she saw Respondent at the Employee Health Service. She told her personal physician about Respondent's conduct. She told her boss that there had been an incident during the examination, but did not tell him any further details. (T. 291-292, T. 297)

11. Patient D had no preconceptions about Respondent prior to her examination at the Employee Health Service. She had never heard anything negative about him, had never spoken to anyone about him, and knew nothing about him before she met him. (T. 294)

CONCLUSIONS WITH REGARD TO PATIENT D AND SPECIFICATIONS THREE AND TEN

Respondent did not deny he made contact with this patient's breast. Rather he asserted that the contact was part of a routine breast examination which he was required to do under the Hospital Code 10 NYCRR 405.22. Whether or not the provision cited is relevant is ultimately moot since the Committee finds the contact herein bore no semblance to a breast examination. Respondent demonstrated a textbook perfect breast examination (T. 1145) which involves deliberate palpation of both breasts while the woman reclines. The contact described here, however, was merely gratuitous and non-medical in nature.

In so finding, the Committee concludes Patient D was credible. Respondent's suggestion that the contact described was in fact a medical procedure severely erodes his credibility. As will be subsequently more fully developed, the patients herein show a marked resemblance in their descriptions of Respondent's chargeable actions despite the fact that none of the patients had ever met and some were private patients while others were seen as state employees. The common thread of patient abuse through gratuitous non-medical physical contact runs through each of the accounts. This common thread allows these accounts to lend each other credibility while making Respondent less and less worthy of belief.

Factual allegation D is unanimously sustained. With regard to specifications three and ten, the Committee unanimously

finds Respondent's gratuitous non-medical contact with this patient's breast constitutes patient abuse and a violation of both standards of moral conduct.

SPECIFICATIONS THREE AND TEN ARE UNANIMOUSLY SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT E

1. Patient E was formerly employed at J. N. Adam Developmental Center as a therapy aide. During her employment at that facility she sustained injuries to her back which disabled her from her employment. (T. 425-426)

2. Patient E received a letter from her employer advising her that she was to report to the Employee Health Service for an examination to determine the extent of her disability. She also received a long and detailed questionnaire regarding many aspects of her medical and personal history. She filled the questionnaire out completely prior to the examination. (T. 429)

3. Patient E went to the Employee Health Service on July 15, 1982. Her husband accompanied her because Patient E's injury made her unable to drive and made her walking ability uncertain. When Patient E and her husband entered the reception area, the receptionist told Patient E to follow her into another room. Patient E's husband remained in the waiting room. (T. 430-431; Ex. 7)

4. The receptionist took Patient E to an area which had little cubicles with curtains in front for changing, an examination area with an examining table and a chair, and an

office with a desk. The receptionist told Patient E to go into one of the cubicles, remove everything except her underpants, and to put on a gown and tie it in the front. When Patient E questioned why the gown would be tied in the front for a back examination, she was told that was the way Respondent wanted it. (T. 431)

5. Patient E followed the instructions given her by the receptionist. Respondent then entered the room and told her to follow him to his desk and they would go over the questionnaire she had completed. Respondent sat at his desk and Patient E sat on a chair while he went over her questionnaire. (T. 431-432)

6. Respondent asked Patient E the exact date of her injury. She told Respondent that she could not remember the exact date. Respondent became loud and told Patient E that if she could not remember the date of her injury, that the injury must have been insignificant. (T. 432)

7. Respondent asked Patient E about her consumption of alcoholic beverages. There was a multiple choice section on the questionnaire asking about consumption of alcohol. Patient E told Respondent that she was a social drinker, as she had stated in her questionnaire. Respondent told her that she was lying and that he thought she was more than just a social drinker. (T. 433)

8. Following his review of the questionnaire and his eliciting of additional medical history for Patient E, Respondent took her to the examination area. There was no one else present in the room, and the door was closed. (T. 431, 502, 505)

9. Respondent asked Patient E, who was standing in front of him, to hold her hands out in front of her. She had been asked to do that before by other physicians who had examined her. (T. 434-435) Respondent looked at Patient E's fingernails. He told her that she must be nervous about the lies she was telling about her back, because her nails were bitten short. (T. 436-437) Patient E purposely kept her nails short because she worked in a facility where she sometimes had to clean up feces. (T. 437)

10. Respondent pulled down Patient E's lower eyelids and looked into her eyes with his own. He did not use any instruments. He then accused her of being an alcoholic. (T. 437)

11. Respondent told Patient E to kneel on a chair that was against the office wall. Patient E told Respondent that she would have difficulty getting on the chair because of the weakness in her left leg. Respondent told her to get on the chair. Patient E did so, with difficulty. She got into a kneeling position facing the wall. (T. 438-439)

12. Respondent looked at the bottoms of Patient E's feet, and told her that she had calluses on her feet. He told her that she must have been "romping" about having a good time while she was collecting money from the State. (T. 439-440)

13. Patient E got off the chair and stood to face Respondent. He told her to bend forward. When she did so, the gown she was wearing fell slightly open. When Patient E returned to a straight standing position, Respondent reached his hand

inside the gown, took hold of Patient E's left breast, and twisted it, causing her physical pain. (T. 440)

14. Patient E knocked Respondent's arm away. Respondent began yelling at Patient E and told her that if there was anything wrong with her, it was probably a "social disease." (T. 444-445)

15. Patient E got dressed and went back to the waiting room where her husband sat. She was crying, and told him, "let's get out of here now." When they were more than half way home, she told her husband parts of what happened. (T. 445)

16. Patient E was too upset to tell her husband everything immediately. She also feared that if she did so, her husband would return to the Employee Health Service and have a confrontation with Respondent. (T. 445)

17. When Patient E and her husband arrived at their home, he helped her into bed. She immediately called the personnel office at J. N. Adam and reported the incident to Ann Sarney, a clerk there. Patient E told Ms. Sarney that Respondent had attacked her, and asked what kind of doctors J. N. Adam was sending their employees to see. (T. 506-507)

18. Subsequent to her conversation with Ms. Sarney, Patient E talked to her union president, Paul Christopher. He asked her if she was willing to put her complaint in writing, and she said that she was. She filed a formal grievance alleging an improper exam She did not put all the details of Respondent's conduct on the form. (T. 448, 482)

19. Patient E, shortly after her encounter with Respondent, had an appointment with her personal physician. She told her personal physician everything that Respondent had done to her. (T. 450)

20. Prior to her visit to the Employee Health Service, Patient E had had breast examinations from other physicians, and had performed self-examination of her breasts. Respondent's contact with Patient E's breast was different. (T. 442-443)

21. Since her visit to the Employee Health Service, Patient E has undergone two spinal surgeries, a fusion and a laminectomy. (T. 461-462) She has been on Worker's Compensation since 1982. (T. 490) She was terminated from her employment at J. N. Adam because she was no longer able to perform any kind of lifting. (T. 425)

CONCLUSIONS WITH REGARD TO PATIENT E AND SPECIFICATIONS FOUR AND ELEVEN

The Hearing Committee concludes that Patient E was an entirely credible witness. She was forthright and consistent in her answers during direct and cross-examination. Her descriptions, reactions and explanations were credible. The Hearing Committee for reasons stated previously rejects Respondent's testimony regarding Patient E, in that his assertions and explanations were not credible. The Hearing Committee concludes that the events of July 15, 1982 occurred as described by Patient E. Respondent grabbed Patient E's breast and twisted

it. This was not part of a breast examination, nor was it related to any medical procedure. It was a gratuitous non-medical contact. Respondent's verbal and physical actions toward Patient E constituted abuse of a patient, and also constituted conduct in the practice of his profession which evidences moral unfitness to practice the profession by violation of both previously cited definitions. Accordingly factual allegations E.1 through E.6 are sustained.

SPECIFICATIONS FOUR AND ELEVEN ARE UNANIMOUSLY SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT F

1. Patient F is employed at West Seneca Developmental Center as a therapy aide. She has been employed by that facility for ten years. (T. 548-550)

2. On February 20, 1983, Patient F was injured while lifting a patient who went into a seizure. This injury temporarily disabled Patient F from her employment. (T. 550-551, 552-553; Ex. 8)

3. Patient F eventually received a letter from her employer advising her that she was to report to the Employee Health Service for an examination. She went to the Employee Health Service on March 30, 1983. Patient F's husband accompanied her, because Patient F was having difficulty driving in her condition. (T. 552-553)

4. When Patient F and her husband walked into the Employee Health Service office, they sat down in a small waiting area. When it was Patient F's turn, the nurse/receptionist took her "paperwork." The "paperwork" included a questionnaire. The nurse then took Patient F into the back of the office. Her husband remained in the waiting room. (T. 554)

5. Patient F disrobed, except for her underpants, and put on a robe. The nurse returned and weighed her and took her blood pressure. The nurse told Patient F that the Respondent was ready for her, and took her to a little office area where Respondent was seated behind a desk. (T. 554-555)

6. When Patient F walked into Respondent's office, she greeted him. Respondent told Patient F to sit down. (T. 555) Patient F sat in a chair near Respondent's desk. Respondent commenced going through Patient F's questionnaire, and asking her personal and medical questions, some of which she felt were irrelevant and embarrassing. During the course of this discussion, Respondent told Patient F that it was ridiculous that she had been out of work so long when she didn't ever have a broken bone. (T. 557)

7. Respondent, before examining Patient F, said to her "Well, we might as well examine you anyway." He then took Patient F into the examining area. (T. 557)

8. Respondent put one hand under Patient F's chin, and put the other hand behind her neck. He began turning Patient F's neck from side to side, nearly from one shoulder to the other.

Prior to turning Patient F's neck, Respondent did not ask her to perform a range of motion or to demonstrate how far she could turn her neck herself. When Respondent turned Patient F's neck from side to side, it caused her pain. She asked Respondent to stop, because he was hurting her but Respondent continued. Eventually, he did stop. (T. 559, 637, 638)

9. Respondent then asked Patient F to sit on a round stool with wheels which was in the examining room. The stool was up against the wall. Patient F pulled the stool out away from the wall so that she could hold onto something for support as she lowered herself onto the stool. When Patient F was nearly seated, Respondent reached behind her and pushed the stool back up against the wall. He said, "I had it there and that's where I want it." Respondent did not tell Patient F that he was going to move the stool out from under her before he did it. When he moved the stool, it was no longer completely under Patient F. This exposed her to a heightened risk of falling. (T. 561, 613-616)

10. Patient F began crying on the drive home from the Employee Health Service, and told her husband what Respondent had said and done to her. (T. 569)

11. When Patient F and her husband got home, he called her personal physician. Patient F went to see her personal physician the next day, and told him everything that had occurred with Respondent. In addition to her immediate family and her personal physician, Patient F told a few close friends what had happened. (T. 570-571)

12. Following her talk with her personal physician, Patient F sent a letter to the Erie County Medical Society about Respondent's misconduct. She also talked to her union representative. (T. 573; 580-581, 625-627)

CONCLUSIONS WITH REGARD TO PATIENT F AND SPECIFICATIONS FIVE AND TWELVE

The Hearing Committee concludes that Patient F was an entirely credible witness. She was forthright and consistent in her answers during direct and cross-examination. Her descriptions, reactions, and explanations bore the logical semblance of truth.

The Hearing Committee rejects Respondent's testimony regarding Patient F, in that his assertions and explanations were not credible. A theme throughout Respondent's treatment of state employees shows a contempt he had for these persons. He displayed a preconception that they were malingerers and that he was protecting the taxpayers by being rude and abusive. While being rude to patients is not necessarily a violation of state standards, it is noted here because it is a common thread amongst all the testimony. This mutuality of observation tends to bolster the overall credibility of the witnesses who, as previously stated, had never met each other.

The Committee finds the events of March 30, 1983 occurred as described by Patient F. However, the Committee does not find that Respondent moved the stool (Charge F.2) with any

kind of malicious intent. The actions by Respondent toward Patient F under charges F.1 and F.3 were unjustified and evidenced a disregard for Patient F's well-being. Treating a patient in the manner described and causing unnecessary pain constitutes abuse of a patient. However the Committee can find no evidence of conduct in the practice of the profession which evidences moral unfitness.

SPECIFICATION FIVE IS UNANIMOUSLY SUSTAINED.

SPECIFICATION TWELVE IS UNANIMOUSLY NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT G

1. Patient G, at the time of the incidents in the Statement of Charges, was employed by Craig Developmental Center. (T. 663-665)

2. During the course of her employment as a laboratory technician at Craig, Patient G injured her back. The injury was severe enough to require hospitalization, and subsequent strict bed rest. (T. 669-670, Petitioner's Exhibit 9) When she returned to her employment at Craig, Patient G was instructed not to lift more than fifteen pounds. (T. 689-691)

3. Patient G. became pregnant with her fifth child in October 1981, at about the same time that she returned to her employment at Craig. The pregnancy aggravated Patient G's back injury, and she was eventually unable to perform her duties. She was scheduled to be examined by Respondent at the Employee Health Service on May 19, 1982. (T. 690-691; Petitioner's Exhibit 9)

4. Patient G's friend drove the two hour distance to the examination while Patient G reclined on a lumbar cushion. Patient G's friend accompanied her into the office, where they entered a reception area. Patient G gave her name and they sat down. The nurse/receptionist brought over a clipboard of paperwork to complete. Because Patient G was having difficulty sitting up, her friend helped with the paperwork. The nurse returned and took the paperwork and told Patient G to come into the back area of the office. Patient G's friend remained in the waiting room. (T. 671-673)

5. The nurse took Patient G to a dressing room, and instructed her to remove all her clothing, put on a gown, and come out when she was ready. When Patient G opened the curtain to indicate that she was ready, the nurse took her to the examination area, where Respondent was waiting. Respondent asked the nurse to leave, and she did. (T. 673-674)

6. Respondent took Patient G's arm and helped her onto the examining table. He had Patient G lie on her back on the examining table. Prior to having Patient G lie on her back on the examining table, Respondent did not examine her back or any other portion of her body. (T. 674-675)

7. Patient G had put on the paper gown with the opening in the back. Respondent took the gown and lifted it over Patient G's head so that it covered her face. Patient G could not see anything with the gown over her face. When Respondent began

to touch her breasts, Patient G pulled the gown down to her neck so that she could look at him. (T. 675)

8. Respondent touched and fondled Patient G's breasts. The fingers of Respondent's hand were open, not together. He put his open-fingered hand over each entire breast and squeezed them slightly. (T. 676-677)

9. Patient G, prior to her visit to the Employee Health Service, had had many breast examinations from other physicians. Her gynecologist and other doctors have taught her how to do self-examination of her breasts. Respondent's touching of her breasts was different from any breast examination Patient G had ever had. (T. 675, 678-679)

10. Respondent asked Patient G if she felt any numbness due to her injury. She told him that when there was numbness, it would go down the right side of her buttocks and down the back of her right leg, and that there would be a tingling sensation which would go down into the back of her heel and foot. At the time, she was not experiencing any numbness. (T. 680-681)

11. Respondent took a safety pin from his lab coat. He asked Patient G, "Do you feel this?" and then stuck the pointed end of the safety pin in her thigh and ran it all the way down her leg in a continuous scratch. Patient G told Respondent that yes, she could feel that. (T. 681, 739)

12. Respondent told Patient G she could get dressed and left the room. (T. 683)

13. Respondent did not perform any physical examination of Patient G's back. (T. 683, 737-738) Patient G has had many back examinations, and is familiar with the components of such examinations. (T. 684-685) During the entire "examination" at the Employee Health Service, Patient G was lying on her back on the examining table. (T. 683, 737-738)

14. Patient G got dressed and went to Respondent's office. (T. 685-686)

15. Patient G went out to the reception area where her friend was waiting. When they got to the car, Patient G began crying, and told her friend what Respondent had done, including the incident with the safety pin. Her friend looked at Patient G's leg, and noticed that the scratch had bled through Patient G's white maternity pants. (T. 682, 686)

16. Patient G told her husband what had happened as soon as she got home. She also called her personal physician and told him what Respondent had done. Patient G's physician gave her addresses where she should write letters regarding Respondent's misconduct. She wrote and sent at least one letter. (T. 693, 698, 700)

CONCLUSIONS WITH REGARD TO PATIENT G AND SPECIFICATIONS SIX AND THIRTEEN

The Hearing Committee concludes that Patient G was a credible witness. She was forthright and consistent in her answers during direct and cross-examination. Her descriptions, reactions and explanations were credible. The Hearing Committee rejects Respondent's testimony regarding Patient G, in that his assertions and explanations were not credible.

The Hearing Committee concludes that the events of May 19, 1982 occurred as described by Patient G. Respondent's touching of Patient G's breasts was not part of a breast examination, nor was it related to any medical procedure. The manner in which Respondent used the safety pin on Patient G was not a neurological examination, nor was it related to any legitimate medical procedure. Respondent's actions toward Patient G constituted abuse of a patient and conduct by Respondent in the practice of his profession which indicates moral unfitness with regard to both standards.

SPECIFICATIONS SIX AND THIRTEEN ARE UNANIMOUSLY SUSTAINED.

RECOMMENDATIONS

The evidence in this proceeding shows a clear pattern of abuse perpetrated by Respondent upon persons who had placed themselves in compromising positions by virtue of the trust conferred upon Respondent arising from his licensure. But for the fact that Respondent was a trusted member of a professional community, Individual A would not have returned to his office for further employment on March 24. But for the fact that Respondent was a trusted member of a professional community, the patients herein would not have been alone with him under circumstances where the acts proven could have taken place. Respondent has repeatedly and egregiously betrayed the trust conferred upon him by virtue of his licensure. He has repeatedly and egregiously violated the moral standards of the professional community of which he is a member. He has repeatedly and boldly lied to this committee. Perhaps of most concern, he has shown not a scintilla of remorse for his actions. Indeed, it appears from the totality of his testimony that Respondent believed and continues to believe that he performs a public service by rooting out malingerers and treating them with the contempt which he believes they deserve. In sum, there is no hope of rehabilitating this practitioner who stands convicted of multiple counts of abusing individuals with whom he has come in contact within his professional capacity. It is therefore the unanimous recommendation of this Committee

that Respondent's license to practice medicine be REVOKED and that he never be allowed to practice medicine in this state or any other again.

DATED: Albany, New York
1989

Ann Shamberger 6.22.89
ANN SHAMBERGER, CHAIRPERSON
GLENDA D. DONOGHUE, M.D.
THERESE G. LYNCH, M.D.

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

IN THE MATTER :

OF :

LIBARDO ROJAS, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

Hearings in the above entitled proceeding were held on October 25, 1988, December 19, 1988, January 4, 5, 9, 1989 and February 13, 1989. Respondent Libardo Rojas, M.D. appeared by Peter A. Vinolus, Esq., of Counsel. Petitioner appeared by Peter J. Millock, Esq., General Counsel, Cindy M. Fascia, Esq., of Counsel.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

a. The Findings of Fact and Conclusions of the Committee should be accepted in full;

b. The Recommendation of the Committee should be accepted except to the extent the Committee recommended that Respondent never be allowed to practice in New York or elsewhere. That aspect of the Committee's recommendation is beyond the scope of the State's power; and

EXHIBIT "C"

c. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
August 11, 1989

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

LIBARDO ROJAS

CALENDAR NO. 10231

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

   b. That respondent has, during the period of probation, successfully performed 100 hours of public service, to be selected by respondent and previously approved, in writing, by said employee;

   c. That respondent is enrolled in and diligently pursuing, at respondent's expense, a course of training in medical ethics, said course to be selected by respondent and previously approved, in writing, by said employee, and said course to be completed to the satisfaction of said employee during the period of probation unless respondent demonstrates to the satisfaction of said employee that respondent cannot comply with said course requirement and said employee excuses respondent from compliance with said course requirment;

   d. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   e. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;

   f. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office

of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding.

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

LIBARDO ROJAS

CALENDAR NO. 10231

The University of the State of New York

IN THE MATTER

OF

LIBARDO ROJAS
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10231

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10231, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 17, 1990): That, in the matter of LIBARDO ROJAS, respondent, the unanimous recommendation of the Regents Review Committee as to the findings and conclusions of the hearing committee and the Commissioner of Health's recommendation as to those findings and conclusions be accepted as follows, as well as the recommendation of the Regents Review Committee, by majority vote of two to one, as to the measure of discipline recommended by the hearing committee and Commissioner of Health be accepted as follows:

1. The hearing committee's findings of fact and conclusions as to the question of respondent's guilt, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the first specification of the charges based on willful physical abuse and willful physical harassment of a patient, the second specification of the charges

based on willful physical harassment and willful verbal harassment of a patient, the third specification of the charges based on willful physical abuse of a patient, the fourth specification of the charges based on willful physical abuse and willful verbal abuse of a patient, the fifth specification of the charges based on willful physical abuse and willful verbal abuse of a patient to the extent indicated in the hearing committee report, the sixth specification of the charges based on willful physical abuse of a patient, the seventh specification of the charges to the extent indicated in the hearing committee report, the eighth through eleventh specifications of the charges, and the thirteenth specification of the charges, and not guilty of the twelfth specification of the charges;

3. The hearing committee's recommendation as to the measure of discipline be accepted to the extent indicated by the Commissioner of Health, and the Commissioner of Health's recommendation as to the measure of discipline be accepted; and

4. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty. Respondent may, pursuant to Rule 24.7(b) of the Rules of the Board of Regents, apply for restoration of said license after one year has elapsed from the effective date of the service of the order of the Commissioner of Education to be issued herein; but said application shall not be granted automatically;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

LIBARDO ROJAS (10231)

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 23rd day of January, 1990.

/Thomas Sobol

Commissioner of Education