STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

March 13, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Neal S. Simon, Esq.
460 West 34th Street
New York, New York 11590

Gerard Sunnen, M.D.
200 East 33rd Street
Suite 26 J
New York, New York 10016

RE: In the Matter of Gerard Sunnen, M.D.

Dear Ms. Gayle, Mr. Simon and Dr. Sunnen:

Enclosed please find the Determination and Order (No. 96-48) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
OF	:	AND
GERARD SUNNEN, M.D.	:	ORDER
		BPMC-96-48

Benjamin Wainfeld, M.D., **Henry Pinsker, M.D.**, and **Nancy Macintyre, R.N., Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **Nancy M. Lederman**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of hearing dated:	August 11, 1995
Amended Statement of Charges dated:	September 11, 1995
Place of hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001
Petitioner appeared by:	NYS Department of Health By: Ann Hroncich Gayle, Esq. Associate Counsel, Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent appeared by:	Neal S. Simon, Esq. 460 West 34th Street New York, New York 11590

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Hearing dates:	September 20, 1995 November 16, 1995 December 6, 1995 December 13, 1995 January 4, 1996 January 5, 1996 January 9, 1996
Conferences:	September 14, 1995 September 20, 1995 December 6, 1995 January 9, 1996
Deliberation dates:	February 13, 1996

WITNESSES

For the petitioner:
1. Patient A
2. Patient B's father
3. Patient B
4. Christina Casals-Ariet, M.D.

For the respondent:
1. Gerard Sunnen, M.D.
2. John Graham, M.D.

STATEMENT OF CHARGES

Respondent was authorized to practice medicine in New York State on October 9, 1970 by the issuance of license number 107435 and is currently licensed to practice medicine with the New York State Department of Education. On August 14, 1995, Respondent was served with a Notice of Hearing and Statement of Charges. Respondent was charged with misconduct under New York Education Law Section 6530.

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion, gross

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negligence, fraudulent practice, misconduct in the practice of psychiatry due to engaging in sexual conduct with a patient, moral unfitness to practice medicine, willfully harassing, abusing or intimidating patients, and failure to maintain adequate records. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Having heard testimony and considered evidence presented by the Department of Health and the Respondent, respectively, the Hearing Committee hereby makes the following findings.

On the last day of hearings, January 9, 1996, Respondent was given leave to subsequently offer into evidence certain records. A two-page document from First Fortis Life Insurance Company, dated February 1, 1996, was received by the Administrative Law Judge on February 5, 1996 and admitted into evidence without objection as Respondent's Exhibit "G", and considered by the Hearing Committee along with the other evidence introduced and transcripts of the hearing in its deliberations on February 13, 1996.

On November 16, 1995 and on January 9, 1996, the hearing proceeded with the two members present, as authorized by law. Dr. Benjamin Wainfeld, absent on November 16, 1995, affirms that he has read and considered evidence introduced at and the transcript of the hearing of that date. Dr. Nancy Macintyre, absent on January 9, 1996, affirms that she has read and considered evidence introduced at and the transcript of the hearing of that date.

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Citations refer to evidence found persuasive by the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

1. Gerard Sunnen, M.D., the Respondent, is a psychiatrist, authorized to practice medicine in New York State on or about October 9, 1970 by the issuance of license number 107435 by the New York State Education Department. (Ex. 2)

2. Valium, Xanax, and Halcion are benzodiazepines. They can all cause short-term confusion and drowsiness. There are dangers associated with overuse and/or a combination of these drugs with alcohol. They are all potentially addictive. Xanax and Halcion are recommended for short-term (one to three months) use. (T. 364-366, 369-370, 372-374, 376, 380)

3. Fastin is an amphetamine-like substance which is a short-term stimulant. Its legitimate use is short-term administration for appetite control. It has a high potential for addiction and there are dangers of use with alcohol. It is recommended for short-term (one to three months) use. (Ex. 34-a and b; T. 366-368, 374-376, 380, 494-495, 884-886, 1090-1091)

4. It is the psychiatrist's responsibility to make an assessment of the patient's potential for psychological dependence on drugs, and to monitor the patient to ascertain whether the patient is developing a psychological dependence on the drugs the patient is taking. (T. 376-380)

5. The psychiatrist-patient relationship exists whether the treatment is psychotherapy or psychopharmacology. The act of

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writing prescriptions involves exercising medical judgment to make a diagnosis and prescribe appropriate treatment, the essence of the doctor-patient relationship. (T. 488-493, 505-507, 945-948, 967-968, 1059-1060, 1072-1077)

6. When a physician prescribes medication to a patient, that physician has the responsibility to describe the side effects, the risks and the benefits of the medication to the patient, and to use medical judgment as to whether to prescribe a particular medication to a particular person at that particular time. If the patient is impaired, *e.g.*, by abusing medication prescribed by the physician, then that physician assumes/takes responsibility for the effect the medication will have on the patient. (T. 381-383, 1075-1077)

FINDINGS OF FACT AS TO PATIENT A

1. Respondent treated Patient A, a 36-year-old female, at his office, which is located at 200 East 33rd Street, New York, New York, and at other locations from approximately August 1986 to August 1989. (Ex. 3, 4, 5, 6, 7, 8, 9, 10, 11; T. 23, 27, 174-178)

2. A psychiatrist-patient relationship existed between Respondent and Patient A from August 1986 through August 1989. (Ex. 3, 4, 5, 6, 7, 8, 9, 10, 11; T. 433-434, 488-493, 945-948, 967-968)

3. Respondent's diagnosis of Patient A's condition in August 1986 was mixed anxiety depression syndrome with agoraphobia. At a later time, his diagnosis was posttraumatic stress disorder. (Ex. 4, p. 1; Ex. 5, p. 28; Ex. 6, p. 36-37; T. 410-413)

4. At his first session with Patient A, Respondent began treatment consisting of supportive and insight oriented psychotherapy, and

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medication. (Ex. 4, p. 2; Ex. 5, p. 10; T. 854)

5. Respondent treated Patient A in his office on a weekly basis from approximately August 1986 to approximately December 1986, and then every other week from approximately January 1987 to late 1988. The sessions lasted approximately 45 to 50 minutes each. Patient A discussed what she was doing, who she was going out with, her goals, and her family. (Ex. 6, p. 62-71, Ex. 8; T. 30, 32-34, 40-44, 48, 71-73, 179-180, 189-190, 309-311, 488-493, 495-496)

6. During Patient A's first visit with Respondent in August 1986, Respondent took a history from her and proceeded to prescribe the drugs she said she had been taking (Valium and Fastin), and then continued to prescribe said drugs throughout the three year course of treatment. (Ex. 9, 10, 11; T. 28-29, 31, 180-183, 187-189, 811-812)

7. Respondent instructed Patient A not to fill the prescriptions at the same drugstore each week, but to change drugstores, and Patient A, from approximately 1986 to 1989, filled the various prescriptions given to her by Respondent at several different pharmacies. (Ex. 9, 10, 11; T. 35, 133-137, 194-207)

8. Prior to being treated by Respondent, Patient A used Fastin and Valium occasionally; she took one Fastin approximately three times per week and a few Valium approximately three times per week. (T. 47-48, 181-187)

9. Patient A's intake of Valium and Fastin increased while she was Respondent's patient. (Ex. 9, 10, 11; T. 133-137, 183-187, 282-284)

10. In approximately late November 1988, Patient A ceased going to

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Respondent's office for sessions, and Respondent began visiting Patient A at her apartment from approximately November 1988 to March 1989, during which time he continued to prescribe Valium and Fastin, and also Prozac and Xanax, to Patient A. (Ex. 9, 10, 11; T. 48-58, 67-68, 79-81)

11. From approximately 1988 to 1989, during the course of Respondent's prescribing the aforesaid drugs to Patient A, Respondent both provided Patient A with alcohol to consume and consumed alcohol with her. (Ex. 9, 10, 11; T. 54, 56, 57-58)

12. On several occasions from approximately November 1988 to August 1989, Respondent went to Patient A's home, ate, drank alcohol, engaged in sexual activity with Patient A, and provided Patient A with various prescriptions and refills. (Ex. 9, 10, 11; T. 51-58, 68-69, 73, 79-81, 288-291, 308-309)

13. During the course of treatment, Patient A asked Respondent to assist her in her attempts to cease taking Valium and other drugs, and refer her to another physician, psychiatrist, or therapist, but Respondent failed to do either. (Ex. 9, 10, 11; T. 59-68, 277-279, 288-291, 300-303, 304-308, 888-892)

14. Patient A eventually obtained the name of a female psychiatrist, Dr. Barbara DeBetz, from the cover of a book that Respondent had given her (Respondent and Dr. DeBetz co-wrote the book), and Patient A became Dr. Debetz' patient. (T. 75-79, 244-250)

15. On various occasions, from 1986 to 1989, when Patient A appeared at Respondent's office for treatment while she was under the influence of having taken too many drugs, Respondent failed to

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recognize this state. (Ex. 9, 10, 11; T. 43-46)

16. From approximately January 1989 through the summer of 1989, Respondent engaged in sexual relations with Patient A. (Ex. 9, 10, 11; T. 56-57, 64-65, 68-69, 83-86)

17. During the course of Respondent's engaging in sexual relations with Patient A, Respondent informed Patient A that this would enhance or improve or make therapy better. (T. 69, 178)

18. Patient A and Respondent ceased having contact with each other in approximately the fall of 1989. In approximately September 1990, Patient A reported Respondent to the American Psychiatric Association (APA), and she subsequently brought a civil suit against Respondent. Following the filing of the complaint and civil suit, Respondent contacted both Patient A and her family and attempted to convince Patient A (directly, and with the help of her parents) not to follow up on her complaint with the APA and with the civil suit. (Ex. 12; T. 140-143, 145-151, 962-966)

19. Respondent failed to produce a record for Patient A. In prior testimony, Respondent testified that the records he maintained contained a few notes regarding the side effects of medication he was prescribing. (Ex. 3, 8, 9, 10, 11; T. 439-440)

CONCLUSIONS AS TO PATIENT A

1. **Allegations A and A-1 and A-1a through A-1e are SUSTAINED.** Respondent treated Patient A from approximately August 1986 to August 1989, during which time he inappropriately treated and prescribed Valium and Fastin for Patient A. (Ex. 3, 4, 5, 6, 7, 8, 9, 10, 11; T. 23, 27-29, 31, 174-178, 180-183, 187-189, 811-812)

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During the course of Respondent's prescribing the aforesaid drugs to Patient A, Respondent both provided Patient A with alcohol to consume and consumed alcohol with her. (Ex. 9, 10, 11; T. 54, 56, 57-58) On several occasions from approximately November 1988 to August 1989, Respondent went to Patient A's home, ate, drank alcohol, engaged in sexual activity with Patient A, and provided Patient A with various prescriptions and refills. (Ex. 9, 10, 11; T. 51-58, 68-69, 73, 79-81, 288-291, 308-309) On various occasions, from 1986 to 1989, when Patient A appeared at Respondent's office for treatment while she was under the influence of having taken too many drugs, Respondent failed to recognize this state. (Ex. 9, 10, 11; T. 43-46)

Allegation A-1f is NOT SUSTAINED. It was not shown by a preponderance of the evidence that Respondent's prescription of medication for Patient A was not in the good faith practice of medicine and not for a proper medical purpose.

2. **Allegations A-2 and A-2a and A-2b are SUSTAINED.** From approximately November 1988 to August 1989, while Patient A was Respondent's patient, Respondent engaged in sexual activity with Patient A. (Ex. 9, 10, 11; T. 51-58, 68-69, 73, 79-81, 288-291, 308-309) Respondent informed Patient A that this would enhance or improve or make therapy better. (T. 69, 178)

3. **Allegation A-3 is SUSTAINED.** Respondent failed to maintain a record for Patient A which accurately reflected the care and treatment rendered to Patient A. (Ex. 3, 8, 9, 10, 11; T. 439-440)

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FINDINGS OF FACT AS TO PATIENT B

1. Respondent treated Patient B, a 32-year-old female, from approximately October 1985 to May 1991. (Ex. 15, 16, 18, 19, 20, 35; T. 569, 592-593, 602-603, 608-609, 615, 637-639, 654-655, 677-681, 684-685)

2. A psychiatrist-patient relationship existed between Respondent and Patient B between 1986 and 1991. (Ex. 15, 16, 18, 19, 20, 35; T. 505-507)

3. In October 1985, Respondent's diagnosis of Patient B was anxiety. Nothing in Respondent's record indicates what the planned course of treatment for Patient B was, although medication was prescribed. (Ex. 15; T. 500-503, 978-979)

4. Patient B's first session with Respondent lasted approximately 45 minutes. From Patient B's third session on, sessions lasted from approximately 45 minutes to 2-1/2 hours. During these sessions, Respondent and Patient B talked, ate, drank alcohol and other beverages, and eventually they engaged in sexual activity. Respondent also massaged Patient B and performed hypnosis upon Patient B. Following some of these sessions, Patient B took cabs from Respondent's office in Manhattan to her home in Queens, for which Respondent sometimes paid the fare. (T. 580-589, 592-593, 595-608, 610-614, 693-699)

5. From approximately 1986 to 1990, while Patient B was Respondent's patient, Respondent engaged in sexual relations with Patient B. (Ex. 16, 18, 19, 20, 35; T. 581, 595-605, 610-612, 615, 689-701, 734-735, 740-742, 1113-1118)

6. From approximately 1988 to 1989, while Patient B was

Respondent's patient, Respondent took nude and other photographs of Patient B, and caused or allowed Patient B to take photographs of Respondent. (Ex. 24; T. 642-643, 661-663)

7. From approximately 1985 to 1991, Respondent prescribed various medications to Patient A, including, but not limited to, Triavil, Ativan, Xanax, Halcion, Prozac, Tenuate, Didrex, Percocet, Wellbutrin, Klonopin, Lithonate, and vaginal and other creams. (Ex. 15, 18, 19, 20; T. 501-502, 577, 593, 615-617, 622, 628, 631-632, 636, 656-658, 686-689, 1062-1063)

8. In approximately October 1989, Respondent referred Patient B to another physician for said physician to prescribe medication for Patient B, and Respondent continued to prescribe medication for Patient B. (Ex. 18, 19, 20; T. 704-706, 775-776)

9. On multiple occasions during the course of Patient B's treatment by Respondent, while Respondent and/or another psychiatrist to whom Respondent referred Patient B were prescribing various drugs, including, but not limited to, Xanax and Halcion, to Patient B, and while Patient B was taking same, Respondent provided Patient B with alcohol to consume. This occurred both during psychotherapy sessions and at other times. (Ex. 18, 19, 20; T. 326-327, 341, 583-585, 588-589, 617-622)

10. During the course of the psychiatrist-patient relationship between Respondent and Patient B, Respondent gave Patient B gifts, including but not limited to, a computer, a facsimile machine, an exercise bike, perfumes and perfume bottles. (Ex. 21, 22; T. 341-342, 623, 643-644, 648-651, 658-660, 773-774, 1115-1116, 1169)

11. During the course of psychiatrist-patient relationship between

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Respondent and Patient B, Respondent accepted gifts from Patient B. (Ex. 23; T. 640, 660-661, 1168-1169)

12. From approximately 1988 to 1989, Respondent encouraged Patient B to seek various elective surgical procedures for which Respondent paid. (T. 645-647, 731-734)

13. In approximately the summer of 1988 or 1989, Respondent took Patient B to the Poconos for approximately one day and one night, and Respondent paid for same. (T. 641-642, 1118, 1170, 1218-1219)

14. From approximately 1986 to 1991, Respondent socialized with Patient B and Patient B's father, and Respondent socialized with Patient B and Respondent's father. (Ex. 24; T. 323-329, 335-337, 339-343, 346-347, 612-615, 624-627, 640-641, 648, 664-665, 1109-1113, 1116-1117)

15. In approximately 1989 or 1990, Patient B's condition deteriorated to the extent that she could not properly care for herself. (T. 329-339, 627-632)

16. From approximately 1989 to 1991, when Patient B's condition deteriorated to the point where she was unable to work, Respondent provided both medical treatment and financial support to Patient B. (T. 627-632, 644, 711-716, 735, 744-747)

17. In approximately February 1991, Patient B's condition had further deteriorated and she was admitted to the Psychiatric Department at Booth Memorial Hospital. Patient B signed herself out of the hospital against medical advice. There is no evidence that Respondent encouraged her to leave the hospital or informed her that he would care for her. (Ex. 17; T. 725-726)

18. On various occasions during the course of treatment, Patient

B asked Respondent to assist her in her attempts to cease taking drugs and to refer her to another physician or hospital, but Respondent failed to do so. (Ex. 18, 19, 20; T. 627-633)

19. Respondent's record for Patient B included entries for four dates only from approximately October 1985 to June 1986, which did not reflect the care and treatment rendered to Patient B. Various medications prescribed through 1991 and referral to another physician in 1989, as described in Paragraphs 7 and 8, above, were not part of Patient B's record. (Ex. 15, 16, 18, 19, 20, 35; T. 521-523, 1140, 1149-1151)

CONCLUSIONS AS TO PATIENT B

1. **Allegations B and B-1 and B-1a and B-1b are SUSTAINED.** Respondent treated Patient B from approximately October 1985 to May 1991. (Ex. 15, 16, 18, 19, 20, 35; T. 569, 592-593, 602-603, 608-609, 615, 637-639, 654-655, 677-681, 684-685) From approximately 1986 to 1990, while Patient B was Respondent's patient, Respondent engaged in sexual relations with Patient B. (Ex. 16, 18, 19, 20, 35; T. 581, 595-605, 610-612, 615, 689-701, 734-735, 740-742, 1113-1118) From approximately 1988 to 1989, while Patient B was Respondent's patient, Respondent took nude and other photographs of Patient B, and caused or allowed Patient B to take photographs of Respondent. (Ex. 24; T. 642-643, 661-663)

2. **Allegations B-2 and B-2a through B-2g and B-2i and B-2j are SUSTAINED.** During the course of the psychiatrist-patient relationship between Respondent and Patient B, Respondent gave Patient B gifts, including but not limited to, a computer, a

facsimile machine, an exercise bike, perfumes and perfume bottles. (Ex. 21, 22; T. 341-342, 623, 643-644, 648-651, 658-660, 773-774, 1115-1116, 1169) Respondent also accepted gifts from Patient B. (Ex. 23; T. 640, 660-661, 1168-1169) From approximately 1988 to 1989, Respondent encouraged Patient B to seek various elective surgical procedures for which Respondent paid. (T. 645-647, 731-734) In approximately the summer of 1988 or 1989, Respondent took Patient B to the Poconos for approximately one day and one night, and Respondent paid for same. (T. 641-642, 1118, 1170, 1218-1219) From approximately 1986 to 1991, Respondent socialized with Patient B and Patient B's father, and Respondent socialized with Patient B and Respondent's father. (Ex. 24; T. 323-329, 335-337, 339-343, 346-347, 612-615, 624-627, 640-641, 648, 664-665, 1109-1113, 1116-1117)

From approximately 1989 to 1991, when Patient B's condition deteriorated to the point where she was unable to work, Respondent provided both medical treatment and financial support to Patient B. (T. 627-632, 644, 711-716, 735, 744-747) On various occasions during the course of treatment, when Patient B was under the influence of too many drugs, Respondent failed to provide appropriate treatment for her. Patient B asked Respondent to assist her in her attempts to cease taking drugs and to refer her to another physician or hospital, but Respondent failed to do so. (Ex. 18, 19, 20; T. 627-633)

Allegation B-2h is NOT SUSTAINED. There was not sufficient evidence in the record that Respondent encouraged Patient B to leave the hospital or informed her that he would care for her.

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(Ex. 17)

Allegations B-2k is NOT SUSTAINED. It was not shown by a preponderance of the evidence that Respondent's prescription of medication for Patient A was not in the good faith practice of medicine and not for a proper medical purpose.

3. **Allegation B-3 is SUSTAINED.** Respondent failed to maintain a record for Patient B which accurately reflected the care and treatment rendered to Patient B. (Ex. 15, 16, 18, 19, 20, 35; T. 521-523, 1140, 1149-1151)

CONCLUSIONS

In reaching its factual conclusions about Respondent's treatment of Patients A and B, the Hearing Committee found the testimony of Patient A, Patient B, and Patient B's father to be generally credible. The Committee also found the testimony of the Department's expert, Christina Casals-Ariet, M.D., and Respondent's expert and character witness, John Graham, M.D., to be credible. The Committee found that Respondent's testimony was not credible, but was generally self-serving and inconsistent.

In reaching its conclusions, the Hearing Committee notes its opinion that the Respondent deviated from professional standards in regard to his failure to evaluate, monitor, and treat the conditions of Patients A and B while prescribing medication for them and the initiation and conduct of sexual activity with both Patients A and B while they were under his care as a psychiatrist.

The Committee finds Respondent's pursuit of a sexual relationship with both patients particularly reprehensible in light

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of his responsibilities as a psychiatrist, the vulnerability of Patients A and B that caused each of them to seek out the services of a psychiatrist, and the trust placed in him by each patient as her psychiatrist. Respondent blatantly and flagrantly betrayed and violated that trust, exploiting both Patient A and Patient B and in each case leaving them in worse condition than they were when they sought his services as a psychiatrist.

The Committee finds that the psychiatrist-patient relationship existed for Respondent and Patient A from approximately August 1886 to August 1989 and for Respondent and Patient B from approximately October 1985 to May 1991, as demonstrated by his repeated writing of prescriptions for both patients over the course of those several years. The act of writing prescriptions involves exercising medical judgment to make a diagnosis and prescribe appropriate treatment, the essence of the doctor-patient relationship. The Committee rejects Respondent's contention that Patients A and B were former patients at any time during these time periods. (Ex. 3, 4, 5, 6, 7, 8, 9, 10, 11, 15, 16, 18, 19, 20, 35; T. 433-434, 488-493, 505-507; 945-948, 967-968, 1059-1060, 1072-1077)

The psychiatrist-patient relationship exists whether the treatment is psychotherapy or psychopharmacology. The psychiatrist-patient relation between Respondent and Patient A included psychotherapy and medication. Respondent's treatment of Patient B included elements of psychotherapy as well as medication prescribed. (T. 488-493, 505-507, 945-948, 967-968, 1059)

Because the Hearing Committee finds a psychiatrist-patient relationship existed at all times relevant to the Statement of

Charges, the Committee makes no conclusions about the propriety of a sexual relationship between a psychiatrist and a former patient.

At the same time as they were under his care as a psychiatrist, Respondent failed to evaluate, treat, and monitor Patients A and B in accordance with acceptable standards of care. Prescription of psychoactive medications (Fastin and Valium) requires ongoing attention to the emergence of side effects and the development of habituation or addiction. When habituation or addiction is present, as in the case of Patient A, responsible treatment requires reevaluation of the therapeutic regimen and vigorous efforts to deal with the addiction, which is potentially a lethal disease. (T. 43-46, 366-370, 372-383, 494-495, 884-886, 1075-1077, 1090-1091)

In the case of Patient A, this was not done. Respondent maintained Patient A at increasing levels of Fastin and Valium. (T. 133-137, 183-187, 282-284) In the case of Patient B, Respondent continued to prescribe a regimen of medication while the patient's condition severely deteriorated. (T. 627-632, 644, 711-716, 735, 744-747) Respondent did not assist Patient A or Patient B in ceasing to take drugs and did not refer either of them for other treatment requested or needed. (Ex. 9, 10, 11, 18, 19, 20; T. 59-68, 277-279, 288-291, 300-308, 627-633, 888-892) His breach of care demonstrated inexcusable lack of insight and judgment, and a blatant disregard for the well-being of his patients.

CONCLUSIONS OF LAW

Based upon the foregoing, the Hearing Committee makes the

following Conclusions with regard to the Specifications.

All votes of the Hearing Committee were unanimous.

1. The First Specification charges Respondent with negligence on more than once occasion based upon factual allegations A and A1a through A1f, A2 and A2a through A2b, A3, B and B1a through B1b, B2a through B2k and B3 of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent's treatment of Patients A and B was negligent within the meaning of New York State Education Law Section 6530(3) in that it did not conform to the standard of care of a reasonably prudent physician under the same circumstances. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The First Specification is SUSTAINED.

2. The Second and Third Specifications charge Respondent with practicing the profession with gross negligence based upon factual allegations A and A1a through A1f, A2 and A2a through A2b, A3, B and B1a through B1b, B2a through B2k and B3 of the Statement of Charges. The Hearing Committee does not sustains these specifications and finds that Respondent's treatment of Patients A and B was not conduct of an egregious nature so as to be grossly negligent within the meaning of New York State Education Law Section 6530(4).

The Second and Third Specifications are NOT SUSTAINED.

3. The Fourth and Fifth Specifications charges Respondent with fraudulent practice based upon factual allegations A and A1a, b, c, f, A2 and A2b, B and B2 and B2k of the Statement of Charges. The

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Hearing Committee does not sustain these specifications and finds that Respondent did not make false representations within the meaning of New York State Education Law Section 6530(2).

The Fourth and Fifth Specifications are NOT SUSTAINED.

4. The Sixth and Seventh Specifications charge Respondent with engaging in sexual conduct with a patient based upon factual allegations A and A2a through A2b and B and B1a through B1b of the Statement of Charges. The Hearing Committee sustains this specification and finds that in the practice of psychiatry, Respondent engaged in physical conduct of a sexual nature with Patients A and B within the meaning of New York State Education Law Section 6530(44). In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Sixth and Seventh Specifications are SUSTAINED.

5. The Eighth and Ninth Specifications charge Respondent with moral unfitness based upon factual allegations A and A1 and A1a through A1f, A2 and A2a through A2b, B and B1 and B1a through B1b, B2 and B2a through B2k of the Statement of Charges. The Hearing Committee sustains these specifications and finds that Respondent's treatment of Patients A and B amounted to conduct which evidences moral unfitness to practice medicine within the meaning of New York State Education Law Section 6530(20). In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Eighth and Ninth Specifications are SUSTAINED.

6. The Tenth and Eleventh Specifications charge Respondent with willfully harassing, abusing, or intimidating Patients A and B

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based upon factual allegations A and A1 and A1a through A1f, A2 and A2a through A2b, B and B1 and B1a through B1b, B2 and B2a through B2h of the Statement of Charges. The Hearing Committee does not sustain these specifications and finds that Respondent's treatment of Patients A and B did not amount to harassing or abusive conduct within the meaning of New York State Education Law Section 6530(31).

The Tenth and Eleventh Specifications are NOT SUSTAINED.

7. The Twelfth Specification charges Respondent with failure to maintain an accurate record based upon factual allegations A and A4 and B and B3 of the Statement of Charges. The Hearing Committee sustains this specification and finds that Respondent failed to maintain an accurate record of treatment for Patients A and B within the meaning of New York State Education Law Section 6530(32). In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Twelfth Specification is SUSTAINED.

PENALTY AND ORDER

The Hearing Committee has found Respondent guilty of negligence on more than one occasion, misconduct in the practice of psychiatry due to physical conduct of a sexual nature with a patient, moral unfitness to practice medicine, and failure to maintain adequate records.

Respondent's breach of his professional responsibilities demonstrates an inexcusable lack of insight and judgment. Respondent willfully disregarded the basic fundamentals of

prescribing medications, in a manner that demonstrates a cavalier disregard of appropriate medical standards. At the same time, Respondent blatantly and flagrantly violated the trust which these two vulnerable patients placed in him, by severely exploiting them for his sexual gratification and leaving them in worse condition than they were when they sought his services as a psychiatrist.

The blatant abuse of the license privilege in such a dangerous manner, for no reason but his own satisfaction, warrants nothing less than the maximum sanction available to this Committee. The Hearing Committee notes that its determination that Respondent's license to practice medicine in the State of New York be revoked is based independently upon each of the specifications of misconduct sustained. In determining a penalty, the Hearing Committee was motivated by its belief that the serious nature of the findings warrants a maximum penalty, as specifically set forth above.

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

Respondent GERARD SUNNEN's license to practice medicine in the State of New York shall be and hereby is **REVOKED.**

DATED: March 11, 1996
New York, New York

BY: _____
Benjamin Wainfeld, M.D.
Chairperson

Henry Pinsker, M.D.
Nancy Macintyre, R.N., Ph.D.

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TO: Ann Hroncich Gayle, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
NYS Department of Health
5 Penn Plaza
New York, New York 10001

Neal S. Simon, Esq.
460 West 34th Street
New York, New York 11590

NEW YORK STATE DEPARTMENT OF HEALTH

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

IN THE MATTER
OF
GERARD SUNNEN, M.D.

AMENDED
STATEMENT
OF CHARGES

Sunnen
Petitioner's Exhibit 1A Entered
DATE 9/14/95
ACCU-SCRIBE REPORTING, NC M.S.B.

GERARD SUNNEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 9, 1970, by the issuance of license number 107435 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, a Psychiatrist, treated Patient A, a 36 year old female, at his office, which is located at 200 East 33rd Street, New York, New York, from approximately August 1986 to August 1989. (The identities of Patients A and B are disclosed in the attached Appendix.)

1. From approximately 1986 to 1989, Respondent inappropriately treated, and prescribed various drugs to, Patient A, including, but not limited to, Valium and Fastin.

   a. During Patient A's first visit with Respondent in August 1986, Respondent took a history from her and then after asking her what kind of drugs she liked to take, proceeded to prescribe the drugs she mentioned, and then continued to prescribe said drugs throughout the course of treatment.

   b. From approximately 1988 to 1989, during the course of Respondent's prescribing the aforesaid drugs to Patient A, and while Patient A was taking same,

Respondent both provided Patient A with alcohol to consume while she was under the influence of the aforesaid drugs, and consumed alcohol with her.

c. On several occasions from approximately November 1988 to August 1989, Respondent went to Patient A's home, ate, drank alcohol, engaged in sexual activity with Patient A, and provided Patient A with various prescriptions and refills.

d. On various occasions during the course of treatment, Patient A asked Respondent to assist her in her attempts to cease taking Valium and other drugs and to refer her to another physician, psychiatrist, or therapist, but Respondent failed to do so.

e. On various occasions, from 1986 to 1989, when Patient A appeared at Respondent's office for treatment while she was under the influence of having taken too many drugs, Respondent failed to provide appropriate treatment for her.

f. The aforesaid prescriptions (and refills) were issued not in the good faith practice of medicine and not for a proper medical purpose.

2. In the course of ongoing psychotherapy, Respondent acted inappropriately toward Patient A as follows:

a. From approximately January 1989 through the summer of 1989, while Patient A was Respondent's patient, Respondent engaged in sexual relations with

Patient A.

b. During the course of Respondent's engaging in sexual relations with Patient A, Respondent informed Patient A that this would enhance or improve or make therapy better.

3. Respondent failed to maintain a record for Patient A which accurately reflects the care and treatment rendered to Patient A.

B. Respondent treated Patient B, a 32 year old female, at his office, which is located at 200 East 33rd Street, New York, New York, from approximately October 1985 to May 1991.

1. In the course of ongoing psychotherapy, Respondent acted inappropriately toward Patient B as follows:

a. From approximately 1986 to 1990, while Patient B was Respondent's patient, Respondent engaged in sexual relations with Patient B.

b. From approximately 1988 to 1989, while Patient B was Respondent's patient, Respondent took nude and other photographs of Patient B, and caused or allowed Patient B to take nude and other photographs of Respondent.

2. Respondent engaged in inappropriate conduct as follows:

a. On multiple occasions during the course of ongoing psychotherapy between Respondent and Patient B, while Respondent and/or another psychiatrist to whom Respondent referred Patient B were prescribing various drugs, including, but not limited

to, Xanax and Halcion, to Patient B, and while Patient B was taking same, Respondent provided Patient B with alcohol to consume. This occurred both during psychotherapy sessions and at other times.

b. During the course of ongoing psychotherapy between Respondent and Patient B, Respondent gave Patient B gifts, including but not limited to, a computer, a facsimile machine, an exercise bike, perfumes and perfume bottles.

c. During the course of ongoing psychotherapy between Respondent and Patient B, Respondent accepted gifts from Patient B.

d. From approximately 1988 to 1989, Respondent encouraged Patient B to seek various elective surgical procedures for which Respondent paid.

e. In approximately the summer of 1988 or 1989, Respondent took Patient B to the Poconos for approximately two nights, and Respondent paid for same.

f. From approximately 1986 to 1991, both while Patient B was in ongoing therapy with Respondent and afterward, Respondent socialized with Patient B and Patient B's father and/or with Patient B and Respondent's father.

g. From approximately 1989 to 1991, when Patient B's condition deteriorated to the point where she was

unable to work, Respondent provided both medical treatment and financial support to Patient B.

h. In approximately February 1991, when Patient B's condition had further deteriorated and she was admitted to the Psychiatric Department at Booth Memorial Hospital, Respondent encouraged her to leave the hospital and informed her that he would care for her; Patient B did, in fact, sign herself out of the hospital against medical advice.

i. On various occasions during the course of treatment, Patient B asked Respondent to assist her in her attempts to cease taking drugs and to refer her to another physician, psychiatrist, or therapist, but Respondent failed to do so.

j. On various occasions during the course of treatment, when Patient B appeared for treatment while she was under the influence of having taken too many drugs, Respondent failed to provide appropriate treatment for her.

k. The various prescriptions (and refills) for Halcion, Xanax, Prozac, and other drugs which Respondent issued during the course of treatment were issued not in the good faith practice of medicine and not for a proper medical purpose.

3. Respondent failed to maintain a record for Patient B which accurately reflects the care and treatment rendered to Patient B.

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SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1995) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1 and A1a-f and/or A2 and A2a-b and/or A3 and/or B and B1 and B1a-b and/or B2 and B2a-k and/or B3.

SECOND AND THIRD SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1 and A1a-f and/or A2 and A2a-b and/or A3.
3. Paragraphs B and B1 and B1a-b and/or B2 and B2a-k and/or B3.

FOURTH AND FIFTH SPECIFICATIONS
FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) by practicing the profession of

medicine fraudulently as alleged in the facts of the following:

4. Paragraphs A and A1 and A1a, b, c, and/or f and/or A2 and A2b.

5. Paragraphs B and B2 and B2k.

SIXTH AND SEVENTH SPECIFICATIONS
ENGAGING IN SEXUAL CONDUCT WITH A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(44)(McKinney Supp. 1995) by engaging in physical contact of a sexual nature with a patient, as alleged in the facts of:

6. Paragraphs A and A2 and A2a-b.

7. Paragraphs B and B1 and B1a and/or b.

EIGHTH AND NINTH SPECIFICATIONS
MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1995) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

8. Paragraphs A and A1 and A1a-f and/or A2 and A2a-b.

9. Paragraphs B and B1 and B1a-b and/or B2 and B2a-k.

TENTH AND ELEVENTH SPECIFICATIONS
WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law §6530(31)(McKinney Supp. 1995) by willfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the facts of:

10. Paragraphs A and A1 and A1a-f and/or A2 and A2a-b.

11. Paragraphs B and B1 and B1a-b and/or B2 and B2a-h.

TWELFTH AND THIRTEENTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1995) by failing to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, as alleged in the facts of:

12. Paragraphs A and A4.

13. Paragraphs B and B3.

DATED: Sept 11, 1995
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

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