STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

September 7, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Elliott H. Sweetser, M.D.
2525 Peter's Lane
Schenectady, New York 12308

Nicholas J. Grasso, Esq.
Grasso, Rodriguez, Purtori
and Grasso
751 State Street
Schenectady, New York 12307

Michael Hiser, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower Building - Room 2412
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Elliott H. Sweetser, M.D.

Dear Dr. Sweeetser, Mr. Grasso and Mr. Hiser:

Enclosed please find the Determination and Order (No. BPMC-93-133) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler/nam

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER OF ELLIOTT H. SWEETSER, M.D.	HEARING COMMITTEE DETERMINATION AND ORDER NO. BPMC-93-133

MRS. ANN SHAMBERGER, CHAIRPERSON, **JOSEPH G. CHANATRY, M.D.** and **S. MOUCHLY SMALL, M.D.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee on all hearing days except August 21, 1992 when Administrative Law Judge **LARRY STORCH** served as the Administrative Officer.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	June 26, 1992
Pre-Hearing Conferences:	July 27, 1992 July 30, 1992
Hearing Dates:	July 30, 1992 August 21, 1992 'October 22, 1992 October 27, 1992

October 29, 1992
December 22, 1992
January 5, 1993
February 4, 1993
February 11, 1993
March 11, 1993
June 1, 1993

First Amended Statement of Charges:	July 23, 1992
Second Amended Statement of Charges:	July 29, 1992
Place of Hearing:	NYS Department of Health Corning Tower Building Empire State Plaza Albany, New York
Date of Deliberations:	June 15, 1993 August 6, 1993
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Michael Hiser, Esq. Assistant Counsel
Respondent appeared by:	Grasso, Rodriguez, Purtori and Grasso 751 State Street Schenectady, New York 12307 BY: Nicholas J. Grasso, Esq. of Counsel

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with conduct in the practice of medicine which evidences moral unfitness to practice medicine; with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient; with practicing the profession of medicine with gross negligence; with practicing the profession of medicine with gross incompetence; with practicing the profession of medicine

with negligence on more than one occasion; with practicing the profession of medicine with incompetence on more than one occasion and with failing to maintain records.

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

WITNESSES

For the Petitioner:

Patient A
Lee A. Black
Patient B
Melvin Pisetzner, M.D.
Clare Weiner
Donal Reinhard
John Mullaney

For the Respondent:

Ellen Berger
Patrick Liverio
Leila Salmon
Rosemary Barton
Sharon Gillette
Brij Mohan Saran, M.D.
Elliott H. Sweetser, M.D., the Respondent

FINDINGS OF FACT

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

GENERAL FINDING

1. The Respondent is a physician duly licensed to practice medicine in the State of New York on May 22, 1958 under license number 080765 issued by the State Education Department (Pet's. Ex. 4).

2. The Respondent was Board Certified in Psychiatry in 1950. He is 75 years of age and he retired from full time practice in 1987. He retired as a consultant in August 1991 and has been fully retired from the practice of medicine since that time (TR. 1420, 1433, 1439).

FINDINGS ON SEXUAL ISSUES

3. Sherry Gillette was Patient A's alcohol counselor prior to her treatment by the Respondent. Ms. Gilette reports that Patient A made multiple requests to sit on Ms. Gillette's lap; she was seductive and attempted to manipulate the sessions and to control the interviews. Ms. Gillette became increasingly uneasy with Patient A. She felt that she was out of her depth, and realized that Patient A should be transferred to a mental health person with more experience (Pet's. Ex. 3, pp. 5-9; Tr. 1222-1239).

4. Sherry Gillette terminated her care of Patient A on August 27, 1980 and turned the case over to the Respondent (Pet's. Ex. 3, p. 10; Tr. 1183).

5. The Respondent provided psychiatric treatment to Patient A at various times from September 1980 through June 1985, at the Montgomery County Mental Health Clinic, located at St. Mary's Hospital, 427 Guy Park Avenue, Amsterdam, New York 12010 (Pet's. Exs. 3, 11, 18).

6. At the time that Patient A came into treatment with the Respondent, she had engaged in regressive behavior, including bedtime ritual described as nursing from a bottle, and wearing and wetting diapers (Pet's. Ex. 3, pp. 5-6).

7. Patient A testified that after her first session alone with the Respondent the Respondent kissed her on the mouth (Tr. 38-39).

8. Patient A also testified that at her initial session with the Respondent and on numerous occasions thereafter she sat on the Respondent's lap. According to Patient A, this close physical contact led the Respondent to initiate physical contact of a sexual nature, including fondling her breasts and genitals (Tr. 38-41).

9. Patient A testified that the physical contact progressed to overt sexual activity including sexual intercourse; oral sex performed by the Respondent on Patient A; oral sex performed by Patient A on the Respondent; and instances in which the Respondent allowed Patient A to use her hands to stimulate his genitals (Tr. 43-44, 52-63).

10. Patient A made approximately 240 visits to the Respondent's office and according to her testimony they engaged

in sexual intercourse on approximately 80% of the visits (Tr. 65).

11. The Respondent testified that Patient A had attempted to sit on his lap on numerous occasions but that he discouraged her requests to do so. He denies that he ever engaged in any sexual activity or had any sexual contact with Patient A (Tr. 1495).

12. Patient A went to the Respondent's house uninvited on November 4, 1983. A locksmith was at work in the house when she arrived and remained on the premises for at least a couple of hours after she left. Patient A was in the house for approximately 45 minutes and the Respondent was absent from her presence for about 15 minutes (Resp's. Ex. OO; Tr. 1529-1532).

13. The Respondent did not show Patient A his home and any casual knowledge that she had of the premises resulted from her own observations. Patient A was at the Respondent's home only on that one occasion (Tr. 1531).

DISCUSSION OF THE HEARING COMMITTEE RELATIVE TO SEXUAL ISSUES

The Hearing Committee has serious questions regarding the credibility of Patient A. She has been diagnosed as borderline personality; she has a history of alcohol and drug abuse, including the use of LSD (Lysergic Acid Diethylamide) which led to hallucinatory flashbacks; she is manipulative and seductive; she has admitted to frequent episodes of hallucinations and at times has had difficulty in differentiating between fantasy and reality (Pet.'s Ex. 3; Tr. 239, 267-269, 582-584, 1222-1239).

Patient A testified in detail regarding scars or lesions on the Respondent's body, including his penis, which proved to be non existent when he voluntarily submitted to an examination by the Hearing Committee (Tr. 570-581; 1630-1631).

In addition, Patient A's scheduled appointments with the Respondent, with few exceptions, were prior to 3:00 P.M. The group therapy room, where Patient A alleges she and the Respondent obtained cushions for their sexual encounters in his office, was immediately next door and was in use all day, every day for staff meetings, etc. until 2:30 P.M. (Tr. 1151-1152, 1168-1169, 1189-1190, 1460).

The Respondent and those witnesses who appeared on his behalf were all credible. The Respondent himself was knowledgeable, forthright and cooperative, even to the point of voluntarily submitting to a physical examination by the Hearing Committee.

CONCLUSION AS TO SEXUAL ISSUES

After a review of the entire record regarding sexual issues, the Hearing Committee finds that the evidence is inconclusive, and therefore the Committee concludes that there is not a preponderance of evidence to support Patient A's allegations. This applies both to conduct of a sexual nature alleged during the period October 1980 through July 1985 and to sexual conduct alleged during the period July 1985 through April 1986.

FINDINGS AS TO THE RESPONDENT SOCIALIZING WITH PATIENT A

14. Patient A and the Respondent took a number of walks together on the clinic grounds (Pet's. Ex. 3, pp. 51, 67; Tr. 86-87).

15. Patient A and the Respondent had lunch together at the cafeteria at St. Mary's Hospital on a number of occasions during the period of treatment (Tr. 87-88).

16. It was the practice at the Montgomery County Mental Health Clinic, to treat patients in a friendly, relaxed and informal atmosphere. This informality included addressing staff and patients on a first name basis and taking walks around the hospital grounds during therapeutic sessions (Tr. 1277-1279).

17. The cafeteria at St. Mary's Hospital was open to staff, patients and the public in general. Patient A, on numerous occasions, invited herself to a group or staff members table. Patient A was pushy and made it difficult to refuse her intrusions. The Respondent spent no more time in the cafeteria with Patient A than anyone else (Tr. 113, 115-116, 1039, 1083-1085, 1118-1121, 1133-1134, 1192-1195).

CONCLUSION AS TO RESPONDENT SOCIALIZING WITH PATIENT A

Given the circumstances described in the Findings of Fact on this issue, the Hearing Committee concludes that it was not a violation of professional ethics or the standard of care for the Respondent to have taken walks with Patient A on the hospital

grounds or to have eaten lunch with Patient A in the hospital cafeteria during the period of treatment or thereafter during the period June 1985 - December 1986.

FINDINGS AS TO TREATMENT PLAN

18. The Respondent initially prepared a treatment plan for Patient A on October 7, 1981. The plan was updated on May 18, 1982, October 12, 1982, June 7, 1983, October 4, 1983 and March 21, 1984 (Pet's. Ex. 18; Tr, 1387).

19. During the period 1980-1986, treatment goals were discussed during staff meetings at the Montgomery County Mental Health Clinic and there was no requirement to develop treatment plans (Tr. 1025, 1049-1050).

20. At the time Patient A began her treatment with the Respondent, most psychiatrists seeing private patients did not employ a formalized treatment plan (Tr. 1388).

CONCLUSIONS AS TO TREATMENT PLAN

During the period in question, formalized treatment plans were not in general use and on those occasions when they were developed they were often not implemented (Tr. 1387-1390).

FINDINGS AS TO MEDICATIONS ISSUE

21. The medication records for Patient A indicate that during the period November 1980 through May 1983, the Respondent prescribed various tricyclic anti-depressant drugs for Patient A.

Patient A was an outpatient at the clinic and due to her lack of finances, the Respondent would routinely interchange the tricyclic anti-depressants depending on the availability of free samples (Pet.'s Ex. 11, p. 1-2; Tr. 1394).

22. On September 29, 1983, October 27, 1983 and December 7, 1983, the Respondent prescribed Nardil, an MAOI (Mono Amine Oxidase Inhibitor), for Patient A (Pet. Ex. 11, p. 1-2).

23. The Respondent did not obtain plasma levels for the tricyclic anti-depressants which he prescribed for Patient A. Also, he did not obtain plasma levels for the Nardil; but he was following the patient clinically and adjusted the Nardil dosage accordingly (Pet.'s Ex. 3, p. 56).

CONCLUSIONS AS TO MEDICATIONS

Patient A was an outpatient at the clinic. She had limited financial resources.

The Respondent's routine interchanging of tricyclic anti-depressants in relatively small doses to a young adult depending on the availability of free samples, while not common practice, may be acceptable under the circumstances, since all of the tricyclic anti-depressants belong to the same group and could be interchanged without risk to the patient (Tr. 1264-1265).

The Respondent did not obtain serum levels for the tricyclic anti-depressants or the Nardil. Serum levels are generally not required unless the patient displays clinical symptoms of toxicity, which were not present in this case.

FINDINGS AS TO RESPONDENT'S RECORDS

24. The Respondent did not have an organized clinical history or mental status examination of Patient A which could serve as a basis for a differential diagnosis (Pet.'s Ex. 3; Tr. 789-791).

25. The Respondent's progress notes on Patient A are not adequate. The notes do not cover the symptometology of a depressive disorder and whatever changes occurred as a result of medications. They did not reflect the nature of the discussion as they took place. The Respondent was influenced by the patient in what he could write in his notes and when the patient insisted on writing in her own chart he did not make the appropriate follow-up comment (The progress note of May 19, 1982 was written entirely by Patient A.) (Pet. Ex. 3; Tr. 799-804, 1303-1306, 1344-1348).

26. After a five year period of intensive treatment, the termination note, which was delayed for five months after the last visit, was totally inadequate in that it did not reflect the psychopathology, the summary of medication and effectiveness, and plans for the future (Pet.'s Ex. 3, p. 68; Tr. 784-786, 1308-1309).

CONCLUSIONS AS TO RESPONDENT'S RECORDS

The Respondent's records regarding Patient A were inadequate.

The Respondent's reliance on Sherry Gillette's clinical history of the patient was not appropriate. A treating psychiatrist should develop his own history and perform his own psychiatric evaluation to formulate his own diagnosis and treatment plan.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

** The Petitioner withdrew all charges against the Respondent relative to Patient B.

FIRST THROUGH THIRD SPECIFICATIONS: (Moral unfitness)

NOT SUSTAINED as to any of the charges.

FOURTH THROUGH SIXTH SPECIFICATION (Physical contact of a sexual nature)

NOT SUSTAINED as to any of the charges.

SEVENTH THROUGH TENTH SPECIFICATIONS (Gross negligence)

NOT SUSTAINED as to any of the charges.

ELEVENTH SPECIFICATION (Gross incompetence)

NOT SUSTAINED as to any of the charges.

TWELFTH SPECIFICATION (Negligence on more than one occasion)

SUSTAINED as to those charges specified in paragraphs A-7(a), (b) and (c) of the Statement of Charges.

NOT SUSTAINED as to all other charges.

THIRTEENTH SPECIFICATION (Incompetence on more than one occasion)

NOT SUSTAINED as to any of the charges.

FOURTEENTH SPECIFICATION (Failure to maintain records)

SUSTAINED as to those charges specified in paragraphs A-7(a), (b) and (c) of the Statement of Charges.

NOT SUSTAINED as to these charges specified in paragraph A-7(d) of the Statement of Charges.

HEARING COMMITTEE DETERMINATION

The Hearing Committee has voted to **SUSTAIN** three counts of negligence and three counts of failing to maintain records against the Respondent. All other charges against the Respondent are **NOT SUSTAINED** and should be **DISMISSED.**

The Respondent was Board Certified in Psychiatry in 1950. He is 75 years of age and he retired from full time practice in 1987. He retired as a consultant in August 1991 and has been fully retired from the practice of medicine since that time.

The Hearing Committee determines that a **CENSURE AND REPRIMAND** would be the appropriate penalty in this case.

ORDER

The Respondent is hereby **CENSURED AND REPRIMANDED** for the violations as specified in paragraphs A-7(a), (b) and (c) (negligence and failure to maintain records) of the Statement of Charges.

All other charges against the Respondent are **DISMISSED**.

DATED: **Vestal, New York**
August 30, 1993

Mrs. Ann Shamberger
ANN SHAMBERGER, CHAIRPERSON

JOSEPH G. CHANATRY, M.D.
S. MOUCHLY SMALL, M.D.

A P P E N D I X I

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

IN THE MATTER OF ELLIOTT H. SWEETSER, M.D.	NOTICE OF HEARING

Petitioner's EXHIBIT 1 ID. ✓ EVD DATE: 7-27-92 BETSY HELM, CSR, RPR

TO: ELLIOTT H. SWEETSER, M.D.
2525 Peter's Lane
Schenectady, New York

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 30th day of July, 1992 at 10:00 in the forenoon of that day at Room 2509, Corning Tower Building, Empire State Plaza, Albany, New York 12237 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You

shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1992), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall

be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW Section 230-a (McKinney Supp. 1992). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
June 26, 1992

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: Michael A. Hiser
Assistant Counsel
Division of Legal Affairs
Bureau of Professional Medical Conduct
Room 2429
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Telephone No.: (518) 473-4282

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

---X

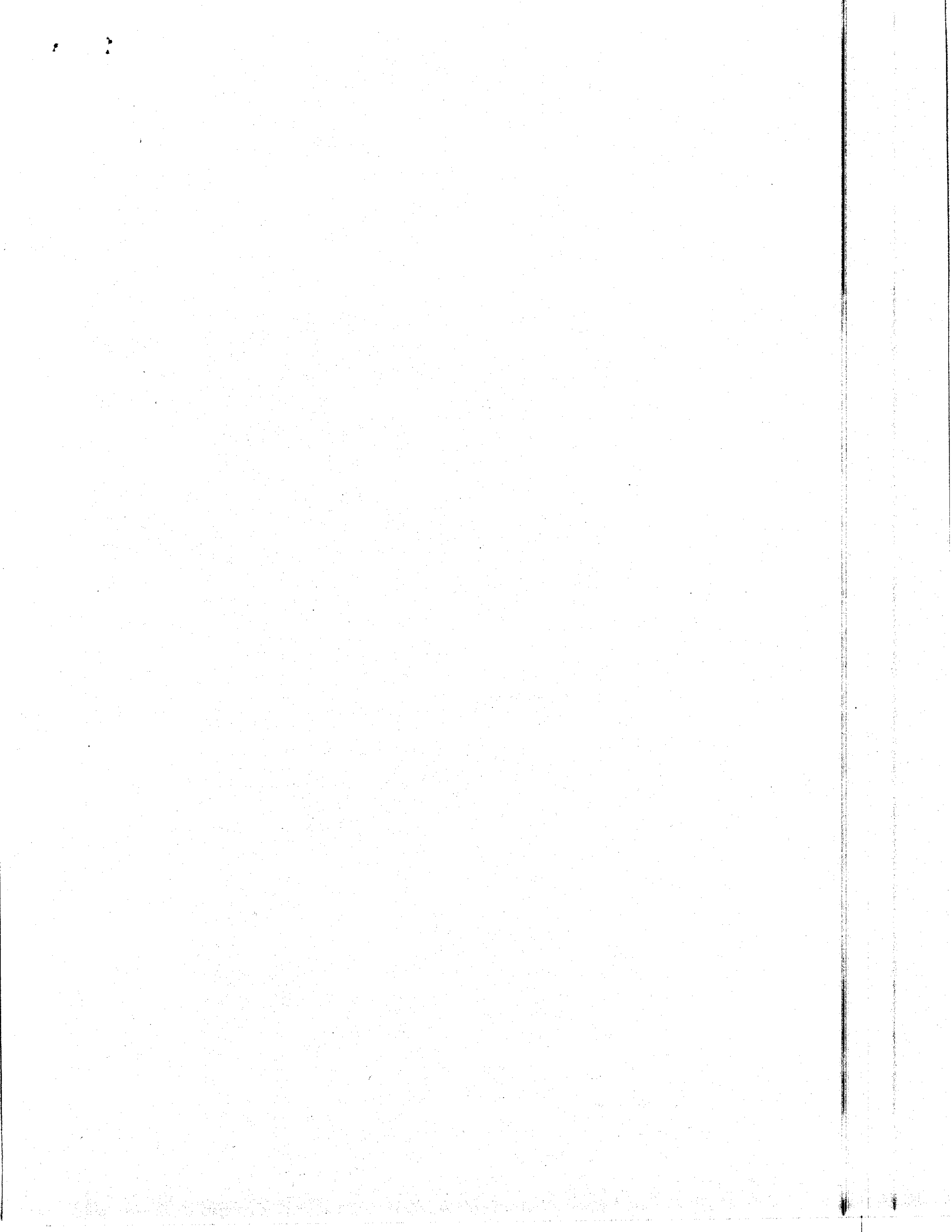
IN THE MATTER OF ELLIOTT H. SWEETSER, M.D.	: : :	STATEMENT OF CHARGES

---X

ELLIOTT H. SWEETSER, M.D. (hereafter, "Respondent") was authorized to practice medicine in New York State on May 22, 1958, by the issuance of license number 080765 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991, through December 31, 1992, from 2525 Peter's Lane, Schenectady, New York 12309-2412.

FACTUAL ALLEGATIONS

A. Respondent provided medical care in the form of psychiatric treatment to Patient A, a 21 year old female, (patients are identified in the Appendix) at various times from September 1980 through July 1985, at the Montgomery County Mental Health Clinic, located at St. Mary's Hospital, 427 Guy Park Avenue, Amsterdam, New York 12010 (hereafter, "the Clinic").



1. Respondent, on numerous occasions from October 1980 through July 1985 at the Clinic during Patient A's appointments, at Patient A's apartment, and at Respondent's residence at 2525 Peter's Lane, Schenectady, New York, engaged in physical contact of a sexual nature with Patient A, including the following:

   a. Respondent fondled Patient A's breasts and genitals.

   b. Respondent allowed Patient A to use her hands to stimulate his penis.

   c. Respondent allowed Patient A to orally stimulate his penis.

   d. Respondent engaged in sexual intercourse with Patient A.

2. Respondent, on numerous occasions from October 1980 through July 1985, socialized with Patient A, including the following:

   a. Respondent took numerous walks with Patient A on the grounds adjacent to the Clinic premises unrelated to any therapeutic purpose.

   b. Respondent ate lunches with Patient A at the St. Mary's Hospital cafeteria in Amsterdam, New York and other restaurants in Amsterdam, New York and Schenectady, New York.

3. Respondent, on numerous occasions from July 1985 through April 1986 at the Clinic, engaged in sexual intercourse with Patient A.

4. Respondent, on numerous occasions from July 1985 through December 1986, socialized with Patient A, including buying breakfast for and eating with Patient A approximately twice a week at the St. Mary's Hospital cafeteria in Amsterdam, New York.

5. Respondent failed to develop and/or implement any treatment plan for Patient A during the September 1980 through July 1985 course of treatment.

6. Respondent, from December 1980 through February 1984, failed to treat Patient A with antidepressant medications in accordance with generally accepted standards of medicine, including the following:

   a. Respondent, in prescribing and/or providing PAMELOR to Patient A, gave an inappropriately large initial dose, failed to allow an adequate time between treatment with PAMELOR and other antidepressant medications, and failed to test Patient A's plasma levels for PAMELOR toxicity.

   b. Respondent, in prescribing and/or providing LUDIOMIL to Patient A, failed to treat with the drug for an adequate length of time to achieve therapeutic results, failed to allow an adequate time between treatment with LUDIOMIL and other antidepressant medications, and failed to test Patient A's plasma levels for LUDIOMIL toxicity.

   c. Respondent, in prescribing and/or providing SINEQUAN (aka DOXEPIN, aka ADAPIN, hereafter "SINEQUAN") to Patient A, failed to allow an adequate time between treatment with SINEQUAN and other antidepressant medications, failed to treat with the drug an adequate time to achieve therapeutic results, inappropriately used SINEQUAN concurrent with other antidepressant medications, and failed to test Patient A's plasma levels for SINEQUAN toxicity.

   d. Respondent, in prescribing and/or providing ASENDIN (AMOXAPIN) to Patient A, failed to use ASENDIN (AMOXAPIN) in accordance with a treatment plan, failed to allow an adequate time between treatment with ASENDIN (AMOXAPIN) and other antidepressant medications, and failed to test Patient A's plasma levels for ASENDIN (AMOXAPIN) toxicity.

   e. Respondent, in prescribing and/or providing NARDIL to Patient A, failed to test Patient A's plasma levels for NARDIL toxicity.

   f. Respondent, in prescribing and/or providing NORPRAMIN to Patient A, failed to allow an

adequate time between treatment with NORPRAMIN and other antidepressant medications, and failed to test Patient A's plasma levels for NORPRAMIN toxicity.

7. Respondent failed to maintain adequate records of his treatment of Patient A, including:

   a. Respondent failed to obtain and/or record a comprehensive history of Patient A.

   b. Respondent failed to prepare and/or record adequate progress notes for Patient A.

   c. Respondent failed to prepare and/or record an adequate termination note for Patient A.

   d. Respondent failed to prepare and/or record a treatment plan for Patient A.

B. Respondent provided medical care to Patient B, a 37 year old female, at various times from mid 1985 through early 1986 at the Clinic.

1. Respondent, on several occasions at the Clinic during Patient B's appointments, engaged in physical contact of a sexual nature with Patient B, including the following:

   a. Respondent rubbed Patient B's back, massaged Patient B's shoulders and put his arm around Patient B's waist.

   b. Respondent patted Patient B on the buttocks.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine, within the meaning of N.Y. Educ. Law sec. 6530(20) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.1(b)(5)] in that Petitioner charges:

1. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c and/or A and A.1.d.
2. The facts in Paragraph A and A.3.
3. The facts in Paragraph B and B.1.a and/or B and B.1.b.

FOURTH THROUGH SIXTH SPECIFICATIONS

PHYSICAL CONTACT OF A SEXUAL NATURE

The Respondent, a psychiatrist, is charged with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient, within the meaning of N.Y. Educ. Law sec. 6530(44) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.4(a)(5)] in that Petitioner charges:

4. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c and/or A and A.1.d.
5. The facts in Paragraph A and A.3.

6. The facts in Paragraph B and B.1.a and/or B and B.1.b.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under New York Educ. Law sec. 6530(4) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

7. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c and/or A and A.1.d.
8. The facts in Paragraphs A and A.3.
9. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.
10. The facts in Paragraphs B and B.1.a and/or B and B.1.b.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under New York Educ. Law sec. 6530(6) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

11. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.

TWELFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under New York Educ. Law sec. 6530(3) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

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

THIRTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under New York Educ. Law sec. 6530(5) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

13. The facts in Paragraphs A and A.2.a, A and A.2.b, A and A.4, A and A.5, A and A.6.a, A and A.6.b, A and A.6.c, A and A.6.d, A and A.6.e, A and A.6.f, A and A.7.a, A and A.7.b, A and A.7.c and/or A and A.7.d.

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

--X

IN THE MATTER OF ELLIOTT H. SWEETSER, M.D.	:	STATEMENT OF CHARGES

--X

ELLIOTT H. SWEETSER, M.D. (hereafter, "Respondent") was authorized to practice medicine in New York State on May 22, 1958, by the issuance of license number 080765 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991, through December 31, 1992, from 2525 Peter's Lane, Schenectady, New York 12309-2412.

EXHIBIT
ID. EVD.
DATE: 7-27-92
BETSY HELM, CSR., RPR

FACTUAL ALLEGATIONS

A. Respondent provided medical care in the form of psychiatric treatment to Patient A, a 21 year old female, (patients are identified in the Appendix) at various times from September 1980 through July 1985, at the Montgomery County Mental Health Clinic, located at St. Mary's Hospital, 427 Guy Park Avenue, Amsterdam, New York 12010 (hereafter, "the Clinic").

1. Respondent, on numerous occasions from October 1980 through July 1985 at the Clinic during Patient A's appointments, at Patient A's apartment, and at Respondent's residence at 2525 Peter's Lane, Schenectady, New York, engaged in physical contact of a sexual nature with Patient A, including the following:

   a. Respondent fondled Patient A's breasts and genitals.

   b. Respondent allowed Patient A to use her hands to stimulate his penis.

   c. Respondent orally stimulated Patient A's genitals.

   d. Respondent allowed Patient A to orally stimulate his penis.

   e. Respondent engaged in sexual intercourse with Patient A.

2. Respondent, on numerous occasions from October 1980 through July 1985, socialized with Patient A, including the following:

   a. Respondent took numerous walks with Patient A on the grounds adjacent to the Clinic premises unrelated to any therapeutic purpose.

   b. Respondent ate lunches with Patient A at the St. Mary's Hospital cafeteria in Amsterdam, New York and other restaurants in Amsterdam, New York and Schenectady, New York.

3. Respondent, on numerous occasions from July 1985 through April 1986 at the Clinic, engaged in physical contact of a sexual nature with Patient A.

4. Respondent, on numerous occasions from July 1985 through December 1986, socialized with Patient A, including buying breakfast for and eating with Patient A approximately twice a week at the St. Mary's Hospital cafeteria in Amsterdam, New York.

5. Respondent failed to develop and/or implement any treatment plan for Patient A during the September 1980 through July 1985 course of treatment.

6. Respondent, from December 1980 through February 1984, failed to treat Patient A with antidepressant medications in accordance with generally accepted standards of medicine, including the following:

   a. Respondent, in prescribing and/or providing PAMELOR to Patient A, gave an inappropriately large initial dose, failed to allow an adequate time between treatment with PAMELOR and other antidepressant medications, and failed to test Patient A's plasma levels for PAMELOR toxicity.

   b. Respondent, in prescribing and/or providing LUDIOMIL to Patient A, failed to treat with the drug for an adequate length of time to achieve therapeutic results, failed to allow an adequate time between treatment with LUDIOMIL and other antidepressant medications, and failed to test Patient A's plasma levels for LUDIOMIL toxicity.

   c. Respondent, in prescribing and/or providing SINEQUAN (aka DOXEPIN, aka ADAPIN, hereafter "SINEQUAN") to Patient A, failed to allow an adequate time between treatment with SINEQUAN and other antidepressant medications, failed to treat with the drug an adequate time to achieve therapeutic results, inappropriately used SINEQUAN concurrent with other antidepressant medications, and failed to test Patient A's plasma levels for SINEQUAN toxicity.

   d. Respondent, in prescribing and/or providing ASENDIN (AMOXAPIN) to Patient A, failed to use ASENDIN (AMOXAPIN) in accordance with a treatment plan, failed to allow an adequate time between treatment with ASENDIN (AMOXAPIN) and other antidepressant medications, and failed to test Patient A's plasma levels for ASENDIN (AMOXAPIN) toxicity.

e. Respondent, in prescribing and/or providing NARDIL to Patient A, failed to test Patient A's plasma levels for NARDIL toxicity.

f. Respondent, in prescribing and/or providing NORPRAMIN to Patient A, failed to allow an adequate time between treatment with NORPRAMIN and other antidepressant medications, and failed to test Patient A's plasma levels for NORPRAMIN toxicity.

7. Respondent failed to maintain adequate records of his treatment of Patient A, including:

   a. Respondent failed to obtain and/or record a comprehensive history of Patient A.

   b. Respondent failed to prepare and/or record adequate progress notes for Patient A.

   c. Respondent failed to prepare and/or record an adequate termination note for Patient A.

   d. Respondent failed to prepare and/or record a treatment plan for Patient A.

B. Respondent provided medical care to Patient B, a 37 year old female, at various times from mid 1985 through early 1986 at the Clinic.

1. Respondent, on several occasions at the Clinic during Patient B's appointments, engaged in physical contact of a sexual nature with Patient B, including the following:

   a. Respondent rubbed Patient B's back, massaged Patient B's shoulders and put his arm around Patient B's waist.

   b. Respondent patted Patient B on the buttocks.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine, within the meaning of N.Y. Educ. Law sec. 6530(20) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.1(b)(5)] in that Petitioner charges:

1. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.e.
2. The facts in Paragraph A and A.3.
3. The facts in Paragraph B and B.1.a and/or B and B.1.b.

FOURTH THROUGH SIXTH SPECIFICATIONS

PHYSICAL CONTACT OF A SEXUAL NATURE

The Respondent, a psychiatrist, is charged with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient, within the meaning of N.Y. Educ. Law sec. 6530(44) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.4(a)(5)] in that Petitioner charges:

4. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.d.
5. The facts in Paragraph A and A.3.

6. The facts in Paragraph B and B.1.a and/or B and B.1.b.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under New York Educ. Law sec. 6530(4) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

7. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.e.
8. The facts in Paragraphs A and A.3.
9. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.
10. The facts in Paragraphs B and B.1.a and/or B and B.1.b.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under New York Educ. Law sec. 6530(6) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

11. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.

TWELFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under New York Educ. Law sec. 6530(3) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

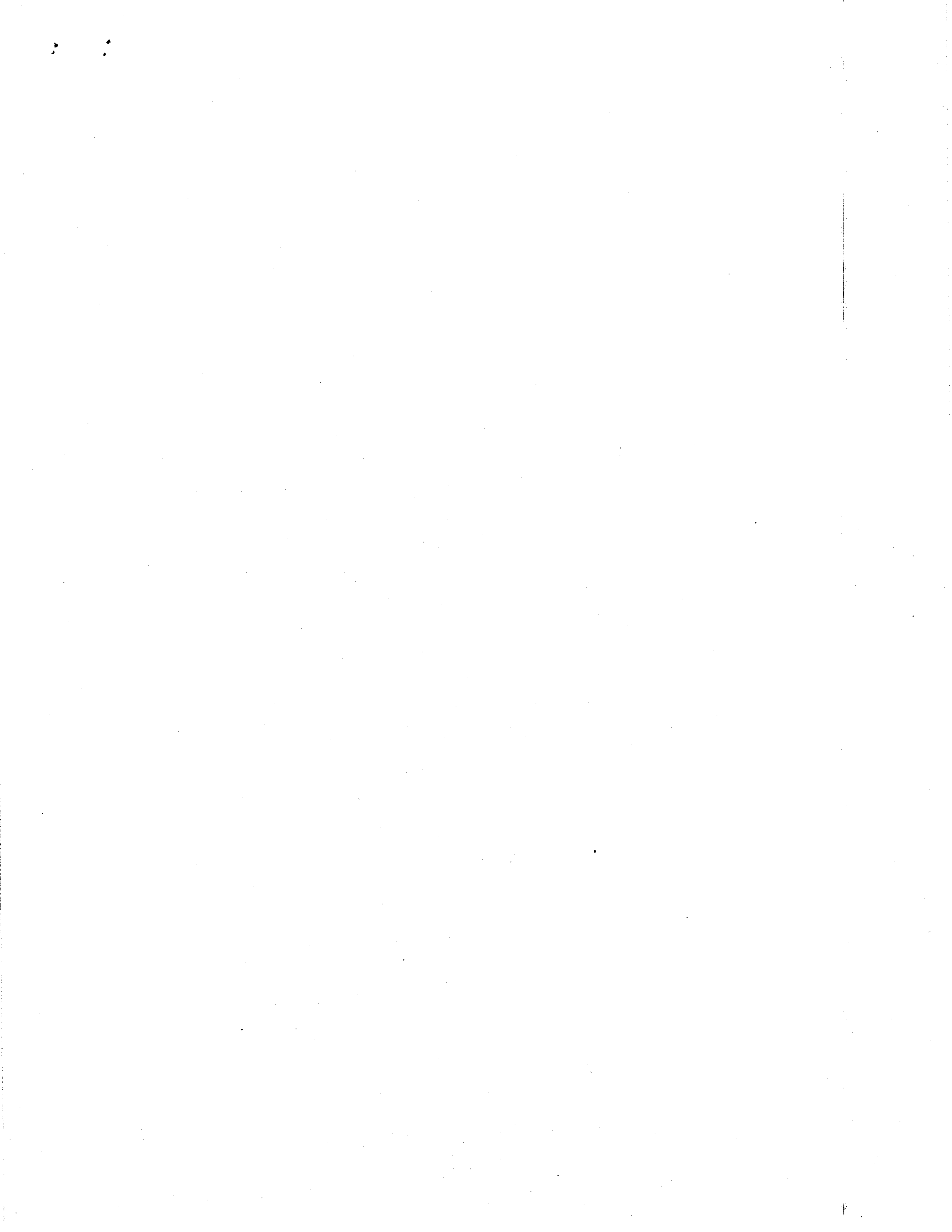
12. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d, A and A.1.e, A and A.2.a, A and A.2.b, A and A.3, A and A.4, A and A.5, A and A.6.a, A and A.6.b, A and A.6.c, A and A.6.d, A and A.6.e, A and A.6.f, A and A.7.a, A and A.7.b, A and A.7.c, A and A.7.d, B and B.1.a and/or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

THIRTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under New York Educ. Law sec. 6530(5) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

13. The facts in Paragraphs A and A.2.a, A and A.2.b, A and A.4, A and A.5, A and A.6.a, A and A.6.b, A and A.6.c, A and A.6.d, A and A.6.e, A and A.6.f, A and A.7.a, A and A.7.b, A and A.7.c and/or A and A.7.d.



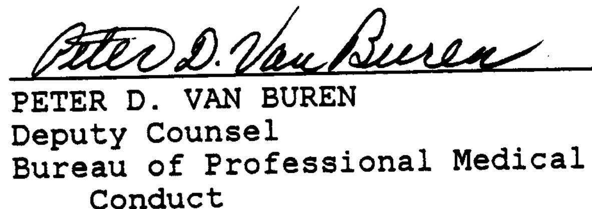
FOURTEENTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with misconduct in the practice of medicine by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, within the meaning of New York Educ. Law sec. 6530(32) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(9) and 8 NYCRR §29.2(a)(3)] in that Petitioner charges:

14. The facts in Paragraphs A and A.7.a, A and A.7.b, A and A.7.c and/or A and A.7.d.

DATED: Albany, New York
July 23, 1992



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

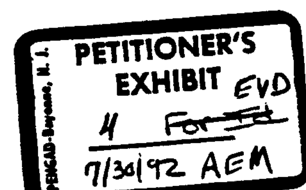
STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF ELLIOTT H. SWEETSER, M.D.	SECOND AMENDED STATEMENT OF CHARGES

ELLIOTT H. SWEETSER, M.D. (hereafter, "Respondent") was authorized to practice medicine in New York State on May 22, 1958, by the issuance of license number 080765 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991, through December 31, 1992, from 2525 Peter's Lane, Schenectady, New York 12309-2412.

FACTUAL ALLEGATIONS

A. Respondent provided medical care in the form of psychiatric treatment to Patient A, a 21 year old female, (patients are identified in the Appendix) at various times from September 1980 through July 1985, at the Montgomery County Mental Health Clinic, located at St. Mary's Hospital, 427 Guy Park Avenue, Amsterdam, New York 12010 (hereafter, "the Clinic").



1. Respondent, on numerous occasions from October 1980 through July 1985 at the Clinic during Patient A's appointments, at Patient A's apartment, and at Respondent's residence at 2525 Peter's Lane, Schenectady, New York, engaged in physical contact of a sexual nature with Patient A, including the following:

   a. Respondent fondled Patient A's breasts and genitals.

   b. Respondent allowed Patient A to use her hands to stimulate his penis.

   c. Respondent orally stimulated Patient A's genitals.

   d. Respondent allowed Patient A to orally stimulate his penis.

   e. Respondent engaged in sexual intercourse with Patient A.

2. Respondent, on numerous occasions from October 1980 through July 1985, socialized with Patient A, including the following:

   a. Respondent took numerous walks with Patient A on the grounds adjacent to the Clinic premises unrelated to any therapeutic purpose.

   b. Respondent ate lunches with Patient A at the St. Mary's Hospital cafeteria in Amsterdam, New York and other restaurants in Amsterdam, New York and Schenectady, New York.

3. Respondent, on numerous occasions from July 1985 through April 1986 at the Clinic, engaged in physical contact of a sexual nature with Patient A.

4. Respondent, on numerous occasions from July 1985 through December 1986, socialized with Patient A, including buying breakfast for and eating with Patient A approximately twice a week at the St. Mary's Hospital cafeteria in Amsterdam, New York.

5. Respondent failed to develop and/or implement any treatment plan for Patient A during the September 1980 through July 1985 course of treatment.

6. Respondent, from December 1980 through February 1984, failed to treat Patient A with antidepressant medications in accordance with generally accepted standards of medicine, including the following:

   a. Respondent, in prescribing and/or providing PAMELOR to Patient A, gave an inappropriately large initial dose, failed to allow an adequate time between treatment with PAMELOR and other antidepressant medications, and failed to test Patient A's plasma levels for PAMELOR toxicity.

   b. Respondent, in prescribing and/or providing LUDIOMIL to Patient A, failed to treat with the drug for an adequate length of time to achieve therapeutic results, failed to allow an adequate time between treatment with LUDIOMIL and other antidepressant medications, and failed to test Patient A's plasma levels for LUDIOMIL toxicity.

   c. Respondent, in prescribing and/or providing SINEQUAN (aka DOXEPIN, aka ADAPIN, hereafter "SINEQUAN") to Patient A, failed to allow an adequate time between treatment with SINEQUAN and other antidepressant medications, failed to treat with the drug an adequate time to achieve therapeutic results, inappropriately used SINEQUAN concurrent with other antidepressant medications, and failed to test Patient A's plasma levels for SINEQUAN toxicity.

   d. Respondent, in prescribing and/or providing ASENDIN (AMOXAPIN) to Patient A, failed to use ASENDIN (AMOXAPIN) in accordance with a treatment plan, failed to allow an adequate time between treatment with ASENDIN (AMOXAPIN) and other antidepressant medications, and failed to test Patient A's plasma levels for ASENDIN (AMOXAPIN) toxicity.

e. Respondent, in prescribing and/or providing NARDIL to Patient A, failed to test Patient A's plasma levels for NARDIL toxicity.

f. Respondent, in prescribing and/or providing NORPRAMIN to Patient A, failed to allow an adequate time between treatment with NORPRAMIN and other antidepressant medications, and failed to test Patient A's plasma levels for NORPRAMIN toxicity.

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   a. Respondent failed to obtain and/or record a comprehensive history of Patient A.

   b. Respondent failed to prepare and/or record adequate progress notes for Patient A.

   c. Respondent failed to prepare and/or record an adequate termination note for Patient A.

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B. Respondent provided medical care to Patient B, a 37 year old female, at various times from 1985 through 1986 at the Clinic.

1. Respondent, on several occasions at the Clinic during Patient B's appointments, engaged in physical contact of a sexual nature with Patient B, including the following:

   a. Respondent rubbed Patient B's back, massaged Patient B's shoulders and put his arm around Patient B's waist.

   b. Respondent patted Patient B on the buttocks.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine, within the meaning of N.Y. Educ. Law sec. 6530(20) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.1(b)(5)] in that Petitioner charges:

1. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.e.
2. The facts in Paragraph A and A.3.
3. The facts in Paragraph B and B.1.a and/or B and B.1.b.

FOURTH THROUGH SIXTH SPECIFICATIONS

PHYSICAL CONTACT OF A SEXUAL NATURE

The Respondent, a psychiatrist, is charged with misconduct in the practice of psychiatry by reason of having physical contact of a sexual nature with a patient, within the meaning of N.Y. Educ. Law sec. 6530(44) (McKinney Supp. 1992) [formerly N.Y. Educ. Law sec. 6509(9) and 8 NYCRR §29.4(a)(5)] in that Petitioner charges:

4. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.d.
5. The facts in Paragraph A and A.3.

6. The facts in Paragraph B and B.1.a and/or B and B.1.b.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under New York Educ. Law sec. 6530(4) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

7. The facts in Paragraphs A and A.1.a, A and A.1.b, A and A.1.c, A and A.1.d and/or A and A.1.e.
8. The facts in Paragraphs A and A.3.
9. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.
10. The facts in Paragraphs B and B.1.a and/or B and B.1.b.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under New York Educ. Law sec. 6530(6) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges:

11. The facts in Paragraphs A and A.6.a, A and A.6.b., A and A.6.c, A and A.6.d, A and A.6.e and/or A and A.6.f.

TWELFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under New York Educ. Law sec. 6530(3) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

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

THIRTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under New York Educ. Law sec. 6530(5) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(2)] in that Petitioner charges that Respondent committed two or more of the following:

13. The facts in Paragraphs A and A.2.a, A and A.2.b, A and A.4, A and A.5, A and A.6.a, A and A.6.b, A and A.6.c, A and A.6.d, A and A.6.e, A and A.6.f, A and A.7.a, A and A.7.b, A and A.7.c and/or A and A.7.d.

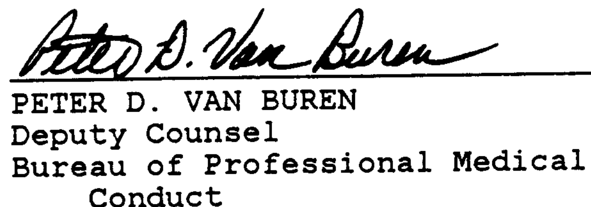
FOURTEENTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with misconduct in the practice of medicine by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, within the meaning of New York Educ. Law sec. 6530(32) (McKinney Supp. 1992) [formerly New York Educ. Law sec. 6509(9) and 8 NYCRR §29.2(a)(3)] in that Petitioner charges:

14. The facts in Paragraphs A and A.7.a, A and A.7.b, A and A.7.c and/or A and A.7.d.

DATED: Albany, New York
July 29, 1992



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