STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

January 18, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower – Room 2509
Albany, New York 12237

Michael L. Koenig, Esq.
Pamela A. Nichols, Esq.
O'Connell and Aronowitz
100 State Street
Albany, New York 12207

Steven St. Lucia, M.D.
Schenectady Surgical Care Association
624 McClellan Street, Suite 402
Schenectady, New York 12304

RE: In the Matter of Steven St. Lucia, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-10) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB: mla

Enclosure

State of New York : Department of Health
State Board For Professional Medical Conduct

COPY

IN THE MATTER

OF

STEVEN ST. LUCIA, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE

ORDER NO.

BPMC 00-10

The undersigned Hearing Committee consisting of **KENDRICK A. SEARS, M.D.**, Chairperson, **DUANE M. CADY, M.D.**, and **NANCY J. MACINTYRE, R.N., Ph.D.** was duly designated and appointed by the State Board for Professional Medical Conduct.

JONATHAN M. BRANDES, ESQ., Administrative Law Judge, served as Administrative Officer.

On June 25, 1999, **DUANE M. CADY, M.D.** resigned from the New York State Board For Professional Medical Conduct. **JOHN H. MORTON, M.D.** was appointed to serve in the place of Dr. Cady. Dr. Morton has filed a statement under Section 230(10)(f) of the Public Health Law attesting he has reviewed the entire record in this proceeding.

The hearing was conducted pursuant to the provisions of Section 230 (10) of the New York Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure act. The purpose of the hearing was to receive evidence concerning alleged violations of Section 6530 of the New York State Education Law by **STEVEN ST. LUCIA, M.D.** (hereinafter referred to as Respondent).

The New York State Board For Professional Medical Conduct (hereinafter referred to as the State or Petitioner) appeared by **HANK GREENBERG, ESQ.**, General Counsel, New York State

Department of Health (hereinafter referred to as DOH). **CINDY M. FASCIA, ESQ.**, Associate Counsel, Bureau of Professional Medical Conduct of counsel. Respondent appeared in person and by **MICHAEL KOENIG, ESQ.,** and **PAMELA NICHOLS, ESQ.,** of counsel to O'Connell and Aronowitz.

Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record. There were numerous motions and briefs which are all part of the record herein whether submitted to the Trier of Fact or not.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision.

RECORD OF PROCEEDING

Notice of Hearing and Statement of Charges dated / served:	02/03/99	
Summary Order Signed / Served:	NA	
Notice of Hearing returnable:	02/24/99	
First Amended Statement of Charges Dated:	NA	
Respondent's Answer Dated / Served:	02/12/99	NA
Pre-Hearing Conference held:	02/10/99	
90/120 days ends:	05/24/99	06/24/99
License Registration Number:	191715	
License Registration Date:	03/17/93	
License Registration Expiration Date	10/31/00	

State Board BPMC appeared by: Cindy M. Fascia, Esq. Associate Counsel
Division of Legal Affairs
Empire State Plaza Corning Tower, Room 2509
Albany, New York 12237

Respondent represented by: Michael L. Koenig, Esq. Pamela A. Nichols, Esq.
O'Connell and Aronowitz
100 State Street
Albany, New York, 12207

Respondent's Present Address: Schenectady Surgical Care Assoc., 624 McClellan St. Suite402 Schenectady NY 12304

Conferences Held: February 10, 24, 25, 1999, March 25, 26, 31 April 1, 7 (phone), 8, 9, 13,14 (phone), 15

Location of Hearing: Hedley, Troy and Cultural Education Building, E.S.P., Albany

Hearing Dates	February 24, 25; March 25, 26, 31, April 1, 8, 9, 13, 15
State Rests	04/01/99
Respondent Rests	04/15/99
Closing Briefs Due:	10/18/99
Closing Brief From State Received :	10/18/99
Closing Brief From Resp. Received:	10/18/99
Record Closed:	10/18/99
Deliberations Scheduled:	05/19/99[1]
Deliberations Held:	10/27/99

[1] Litigation arose from a subpoena issued by Respondent. The deliberations in this matter could not be conducted until the litigation was concluded.

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges five grounds of misconduct. The allegations arise from the from the treatment of five patients during the period 1995 through 1997. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One. Respondent entered a written answer which is attached hereto as Appendix Two. A table which summarizes the conclusions of the Committee is attached hereto as Appendix Three

1. In the First through Third Specifications, Respondent is alleged to have committed acts evidencing moral unfitness as set forth in N.Y. Education Law Section 6530 (20);

2. In the Fourth and Fifth Specifications, Respondent is alleged to have committed gross negligence as set forth in N.Y. Education Law Section 6530 (4);

3. In the Sixth and Seventh Specifications, Respondent is alleged to have committed gross incompetence as set forth in N.Y. Education Law Section 6530 (6);

4. In the Eighth Specification Respondent is alleged to have committed negligence on more than one occasion as set forth in N.Y. Education Law Section 6530 (3);

5. In the Ninth Specification, Respondent is alleged to have committed incompetence on more than one occasion as set forth in N.Y. Education Law Section 6530 (5);

The Board called these witnesses:

1. Patient A
2. Patient B
3. Richard H. Etkin, M.D.
4. [redacted]
5. John Bulova, M.D.
6. Patient C
7. Laura E. Martin

Respondent called these witnesses:

1. Respondent
2. Carol Lynn Keefe
3. Timothy W. Willox, M.D.

SIGNIFICANT LEGAL DECISIONS

Replacement of a Panel Member

On June 25, 1999, Dr. Duane M. Cady resigned from the State Board For Professional Medical Conduct. At the time of his resignation, the testimony and evidence in this proceeding had been submitted. The Committee was awaiting an opportunity to deliberate. The resignation was not related to this proceeding in any way.

Under the provisions of Section 230 (10)(f), when a panel member is no longer able to continue to participate in a hearing that has been initiated, the Chairperson of the Board shall appoint a replacement member. Under the same provision, the replacement member must affirm, in writing, that he or she has read the entire transcript and considered all the evidence in the proceeding. Dr. John H. Morton was appointed to serve on this Committee by the chairperson of the Board. Dr. Morton has filed a written certification attesting that he has read the entire transcript and considered all the evidence in this proceeding.

Litigation Regarding Subpoena of Patient A's Counseling Record

During her direct examination, Patient A disclosed that as a result of the incidents she described involving Respondent, she had employed the services of a psychological counselor. After the receipt of most to the evidence in this proceeding but prior to deliberations, Respondent issued a subpoena for the complete patient record generated by Patient A's psychological counselor.

Notwithstanding the testimony by Patient A that she had seen a counselor as a result of the events she described in her testimony, it was the position of the Administrative Law Judge that Patient A had not waived patient confidentiality as to her entire patient record. However, the Administrative Law Judge, was of the opinion that Respondent may have been entitled to disclosure of any information in the patient record which was directly related to the testimony by Patient A and which would have reflected upon her ability to tell the truth and differentiate between reality and fiction. This opinion was stated during conferences with the parties. It was the intention of the Administrative Law Judge, that the patient record be turned over to him for *in camera* inspection. Upon inspection by the Administrative Law Judge, if there was information to the effect that Patient A could not tell the truth or was unable to differentiate between fantasy and reality, it would have been turned over to the parties for purposes of cross-examination. Information in the patient record that bolstered the testimony of Patient A or any information which did not specifically relate to the events asserted in this proceeding would not have been turned over to the parties and the entire record would have been returned to Patient A as soon as the *in camera* inspection had taken place.

Prior to any inspection by the Administrative Law Judge, Respondent issued a subpoena for the entire patient record maintained by Patient A's counselor. Patient A obtained private counsel and resisted the subpoena. Eventually Supreme Court, Albany County, ruled that the records need not be turned over to Respondent. The Administrative Law Judge did not review the file and no part of it was disclosed to Respondent.

The Trier of Fact was aware that this proceeding had been delayed for some time due to litigation. It was the opinion of the Administrative Law Judge that to allow speculation by the Trier of Fact about the nature of the delay could have inured to the prejudice of the parties. Therefore, at deliberations, the Administrative Law Judge recounted to the Committee the facts

about the delay and the litigation as stated above. The Committee was told that both Patient A and Respondent had acted within their legal rights. The Committee was instructed not to allow the fact that there was litigation to effect their judgement in any way. The Committee was reminded that Respondent had the right to aggressively defend himself. Likewise, Patient A had a right to protect her patient confidentiality.

It was also pointed out that Respondent had had an opportunity to cross-examine Patient A. However, Respondent had not had the opportunity to know whether there existed any information in the counseling record that would have assisted Respondent in the cross-examination of Patient A. The Trier of Fact was also told that cross-examination is a very important part of the concept of Due Process. The Committee was also instructed that the area which had been foreclosed to Respondent was small compared to the totality of the testimony by Patient A. Ultimately, the Committee was instructed that when assessing the credibility of Patient A, they may, but need not, consider that a small portion of information related to Patient A was not available to Respondent for cross-examination. As will be seen later in this decision, the Committee was so convinced of the credibility of Patient A that the entire subject of the litigation became a moot point.

Instructions
to the
Trier of Fact

The Administrative Law Judge delivered the following instructions to the Committee:

1. Negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state.

2. Incompetence is defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice in this state.

3. Gross negligence is defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct.

4. Gross incompetence would be a single act of incompetence of egregious proportions, or multiple acts of incompetence that cumulatively amount to egregious conduct.

5. The term egregious means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

6. There is one standard of medical care in this state. A prudent, competent physician is expected to consider the same medical issues regardless of where he practices. Whether a physician practices in a major teaching hospital, with all the most modern facilities and

staff or in a rural or inner city clinic with less facilities and assistance available, the prudent, competent physician must consider all relevant medical issues.

7. There are some patient treatment issues which reasonable minds may consider to be non-medical in nature. Such issues include, but are not limited to, patient cost, patient inconvenience, patient discomfort, anticipated patient compliance and other relevant issues. The prudent, competent physician is expected to consider these questions as they relate to the individual episode of medical care.

8. The prudent, competent physician may weigh the necessity and patient benefit of a given test, procedure or other treatment issue against the cost of the test or procedure, convenience and discomfort to the patient and anticipated compliance of the patient. Individual patients may raise other pertinent issues as well. The prudent, competent physician is expected to make a well reasoned decision and record his reasons for same.

9. The customs and practices of the medical community in which the physician practices may be considered either as mitigation of a penalty or as one of the factors to be weighed in the physician's thought process as he deliberates the advisability of a given medical procedure. However, the practices of a given medical community cannot insulate a physician from a finding of incompetence, negligence or other misconduct.

10. With regard to a finding of medical misconduct, the Committee must first review Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response.

11. Where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.

12. Patient harm need never be shown to establish negligence or incompetence in a proceeding before the Board For Professional Medical Conduct.

13. State regulations (8 NYCRR [Education] 29.2(3))require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given entry or set of entries and be able to understand a practitioner's course of treatment and the basis for same.

14. With regard to the expert testimony herein, including Respondent's, if any, each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

15. Character evidence is testimony by Respondent or others regarding the overall character or reputation of a Respondent. Character evidence may include a description, of a Respondent's appointments to various positions and his various accomplishments.

16. Character evidence cannot be considered when deliberating whether or not the acts alleged were proven. Nor can character evidence be considered with regard to whether the acts proven constitute medical misconduct as charged.

17. Where the Committee makes a finding of misconduct, the Committee members may, but need not, consider character evidence when determining what, if any, penalty to impose.

18. To sustain an allegation of moral unfitness, the State must show Respondent committed acts which "evidence moral unfitness." There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct is suggestive of, or would tend to prove, moral unfitness. The Committee is not called upon to make an overall judgement regarding the moral character of any Respondent. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgement or other temporary aberration.

19. The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust which is bestowed upon one solely by virtue of his license to practice medicine. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based upon the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon him by virtue of his professional status. This leads to the second aspect of the standard: Moral unfitness can be seen as a violation of the moral standards of the

medical community which the Committee, as delegated members of that community, represent.

20. The standard of proof in this proceeding is "preponderance of the evidence." This means that the State must prove the elements of the charges to a level wherein the Trier of Fact finds that a given event is more likely than not to have occurred. All findings of fact made herein by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

21. While deciding this case, the members may consider only the exhibits which have been admitted in evidence and the testimony of the witnesses as it was heard in this hearing or read from the transcript. However, arguments and remarks of the attorneys or the Administrative Law Judge are not evidence or testimony.

22. If it is found that any witness has willfully testified falsely as to any material fact, that is as to an important matter, the law permits the Trier of Fact to disregard completely the entire testimony of that witness upon the principle that one who testifies falsely about one material fact is likely to testify falsely about everything. The Committee was told that they are not required, however, to consider such a witness as totally unworthy of belief. The Trier of Fact may accept so much of his or her testimony as is deemed true and disregard what is found to be false. The Trier of Fact was told that it is by the processes which was described, that they, as the sole judges of the facts, decide which of the

witnesses they will believe, what portion of their testimony will be accepted and what weight it will be given.

23. Occasionally, the weight to be given evidence is a matter of Law. The Committee was instructed that in such a case, the Administrative Law Judge would issue specific instructions to them.

FINDINGS OF FACT

The findings of fact in this decision were made after review of the entire record. Numbers in parentheses (T._ [Witness x]) refer to transcript pages and identify the witness who made the remark. Exhibits received in evidence are identified by number and by the party who offered the exhibit (Petitioner or Respondent Ex. __;). These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony may have been rejected as irrelevant or redundant.

General Findings of Fact

Respondent, was authorized to practice medicine in New York State on March 17, 1993 by the issuance of license number 191715 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period through October 31, 2000, with a registration address of Schenectady Surgical Care Associates, Suite 202, 624 McClellan Street, Schenectady, New York 12304.

Findings of Fact
Arising From the Care and Treatment
of
Patient A

1. Patient A, at the time that she received medical treatment from Respondent, was 32 years old. Patient A had had a significant gynecological history which had been treated by Dr. Richard Etkin, Patient A's obstetrician and gynecologist. (Pet. Ex. 5; T. 23-24 [Patient A], T. 420 [Etkin])

2. Dr. Etkin had repeatedly discussed hysterectomy with Patient A as a treatment for her condition, but Patient A wanted to postpone hysterectomy as long as possible. (Pet. Ex. 5; T. 421 [Etkin], T. 24-25 [Patient A]).

3. Patient A did not want to have a hysterectomy because she and her husband wanted to have children. Dr. Etkin treated Patient A for infertility with various fertility medications, but Patient A and her husband did not conceive (Pet. Ex. 5; T. 24-25 [Patient A], T. 420-421 [Etkin])

4. In approximately March 1997, a sigmoid mass was identified in Patient A. (Pet. Ex. 4, 5; T. 25-26 [Patient A], T. 421-422, T. 920 [Respondent])

5. The presence of a colon mass required that Patient A undergo a sigmoid resection. Dr. Etkin referred Patient A to Respondent, a general surgeon. (Pet. Ex. 4, 5; T. 26-28 [Patient A], T. 423 [Etkin], T. 918, 920 [Respondent])

6. Respondent first saw Patient A in his office at St. Clare's Hospital of Schenectady (St. Claire's) for medical care on August 7, 1997. (T.21-22 [Patient A])

7. In August 1997, Patient A had been employed [redacted] for thirteen years at a mid-supervisory level. (T.21-22 [Patient A])

8. Although Patient A had been an employee of St. Clare's for years, she did not know Respondent prior to being referred to him for medical care. (T. 27 [Patient A], T. 919 [Respondent])

9. Patient A saw Respondent for a surgical consultation. They discussed her medical condition, and Respondent recommended a sigmoid resection in addition to an abdominal hysterectomy. It was decided that the operations would be performed together. Dr. Etkin would perform the hysterectomy and then Respondent would perform the sigmoid resection. (Pet. Ex. 4, 5; T. 27-28 [Patient A], T. 920-921 [Respondent])

10. Patient A told Respondent she was concerned that the operation and resulting scar would make her unattractive to her husband. (T. 56-57 [Patient A], T. 922-923, 992-993 [Respondent])

11. On August 21, 1997, Patient A underwent surgery at St. Clare's. Dr. Etkin performed a hysterectomy, and Respondent performed a sigmoid resection with primary anastomosis. (Pet. Ex. 4, 5; T. 28 [Patient A], T. 422-423 [Etkin], T. 924 [Respondent])

12. Following the surgery, Patient A was hospitalized at St. Clare's until August 26, 1997, when she was discharged. (Pet. Ex. 4, 5; T. 28 [Patient A], T. 925 [Respondent])

13. While Patient A was hospitalized, Respondent periodically checked on her condition, in person and by telephone calls to her room. (T. 29 [Patient A], T. 926-928, 993-995 [Respondent])

14. Respondent was on vacation during part of Patient A's hospitalization. He had signed the case over to his associate, Dr. Rebenal. Nevertheless, He continued to call Patient A while she was in the hospital that week. (T. 29 [Patient A], T. 994-995 [Respondent])

15. Some days after her discharge, Patient A began to experience constipation, pain and nausea. She was unable to move her bowels. Patient A called Respondent's office and spoke to a staff person. Respondent called Patient A back and advised her to follow a regimen of mineral oil enemas to try to produce a bowel movement. Respondent told

Patient A that he would be on call that weekend, and that if she did not produce a bowel movement, she should call his exchange. (Pet. Ex. 4; T. 30-31 [Respondent])

16. On Saturday, September 6, 1997, Patient A called Respondent's exchange. Respondent returned her call. Patient A told him that she still had not produced a bowel movement, and she felt uncomfortable and ill. Respondent told Patient A that she would need to have an abdominal x-ray and that she should come to St. Clare's Hospital. (Pet. Ex. 4; T. 30-31 [Respondent])

17. Patient A drove to St. Clare's. Respondent was waiting for her at the front door of the Main Lobby. (T. 31-32 [Patient A], T. 933-934 [Respondent])

18. Respondent hugged Patient A, and told her that he was so sorry that she wasn't feeling well, that he would take care of her and that everything would be okay. (T. 32 [Patient A])

19. Respondent put his arm around Patient A's shoulders and escorted her to the registration desk. As they came close to the desk, Respondent removed his arm. (T. 32-33 [Patient A]) Respondent had pre-registered Patient A. (T. 33 [Patient A], T. 934 [Respondent])

20. Respondent then escorted Patient A to the Radiology Department and sat with her because there was no secretary at the desk. Respondent again told Patient A that he was sorry that she wasn't feeling well, and that he would take care of her.

21. Eventually, Respondent and an x-ray technician escorted Patient A to an X-Ray Room, where she laid on the examination table. The technician left the room. Respondent took Patient A's hand and kissed it. He told Patient A that she looked so sad and so sick, and he again told her that he would take care of her. (T. 33-34 [Patient A], T. 934 [Respondent])

22. Patient A asked Respondent not to do this because she felt she was going to start crying, which was not something she would normally do. (T. 33-34 [Patient A])

23. Patient A was worried that there was really something else that was causing her bowel problems and she may have undergone a hysterectomy unnecessarily. She was upset that she had undergone a hysterectomy at age 32 and that she would never be able to have a child. (T. 33-34 [Patient A])

24. Respondent left the X-Ray Room and the x-ray was administered. The technician left with the films. Respondent again came into the room and took Patient A's hand and kissed it. He again told her that everything was going to be okay. He told Patient A to get dressed, that he would go to view the films and let her know what the results were. (T. 35 [Patient A])

25. Patient A got dressed and waited in the Radiology Waiting Room. Respondent waited with her while the films were being developed. Respondent continued to reassure Patient A. He told her he would find out what was causing her physical problems and that she would be fine. He again told her that everything would be all right. (T. 35 [Patient A])

26. Respondent went to look at the films and came back to where Patient A was seated in the Radiology Waiting Room. He told Patient A that they should go to the Main Lobby area of the hospital, where Respondent discussed the results with Patient A. He told Patient A that the x-rays showed that she was full of stool. (T. 36 [Patient A], T. 941 [Respondent])

27. Respondent said that he could send her to the Emergency Department for disimpaction, but that he realized it would be embarrassing for her. He told her that he would write her a prescription for something that would help her move her bowels. (T. 36 [Patient A], T. 941-942 [Respondent])

28. Respondent asked Patient A to come with him to his office. He told Patient A that he did not have a prescription pad with him but there was one in his office. He also told Patient A that he might have some samples of medication in his office. (T. 36 [Patient A], T. 941-942 [Respondent])

29. Patient A and Respondent went upstairs to Respondent's office, which is in a building attached to St. Clare's. There was no one else present in Respondent's office. (T. 37-38 [Patient A], T. 943 [Respondent])

30. Respondent told Patient A to come back into the office area with him, where he wrote a prescription for Lactulose for her. Lactulose is a medication which helps patients to move their bowels. (Pet Ex. 8; T. 38 [Patient A], T. 943-944 [Respondent])

that he wanted to get to know what was behind her beautiful eyes. He told Patient A that she was very sexy. (T. 42 [Patient A])

42. Patient A was taken aback by Respondent saying these things to her. However, there was a part of her that was flattered to hear these things from her physician.

43. Patient A was vulnerable at this time in her life. The hysterectomy, had taken a toll on her feelings about herself as a woman. Patient A expressed the following fears and concerns:

a. She was worried that her husband would no longer find her attractive because of her scarred abdomen;

b. She felt physically unattractive because of how ill she felt;

c. She believed she must look like "a Frankenstein monster" with all her surgical scars;

d. She feared that her husband would no longer find her desirable;

e. She imagined he might be repulsed by her. (T. 42-44 [Patient A, see T. 424-427 [Etkin])

44. Accepted medical standards include the recognition that hysterectomy can be a very significant emotional trauma and can effect not only a woman's reproductive capability but how she feels about herself as a woman. (T. 424-426 [Etkin])

45. Patient A was depressed and emotionally traumatized in the aftermath of her surgery. (T. 425-427 [Etkin])

31. Respondent told Patient A that he wanted to examine her abdomen. Respondent and Patient A went into an Examining Room. Patient A unfastened her jeans and laid down on the examining table, and Respondent examined her abdomen. (T. 38-39 [Patient A])

32. After Respondent finished his examination, Patient A sat up on the examining table. Respondent began to tell Patient A that he was very attracted to her, and that he felt a very strong connection to her. (T. 39 [Patient A])

33. Patient A reacted with shock and disbelief to what Respondent was saying. She told Respondent that she felt a connection to him too. However, Patient A said any connection resulted from the facts that Respondent was her doctor; she felt he had taken good care of her; and he had met her family when she was in the hospital and had taken the time to speak with them after the surgery. (T. 39 [Patient A])

34. Respondent kissed Patient A on the lips. Patient A told him that she was confused and scared. Respondent told Patient A that he just wanted to hug her, which he did. He again told Patient A that everything would be okay. (T. 39-40 [Patient A])

35. Patient A was confused and frightened because the way Respondent had hugged her and kissed her was passionate and very different from the hug he had given her when she had first arrived at St. Clare's that day. (T. 39-40 [Patient A])

36. Respondent stated that Patient A looked very sad. (T. 40-41 [Patient A])

37. Patient A told Respondent that she was indeed very sad. Patient A reminded Respondent that she was quite ill. She reminded Respondent that she was extremely upset over the possibility she had undergone an unnecessary hysterectomy at such an early age, prior to having any children because her symptoms might have been solely a bowel problem after all. (T. 40-41 [Patient A])

38. Patient A told Respondent that she was upset for her husband because she was not able to have children with him. She was upset for her parents and her brother. She stated she believed she had failed all of her family because she had failed to have children and was now forever deprived of her ability to conceive and bear children. (T. 40-41 [Patient A])

39. In reply, Respondent described personal problems. He said that he understood how difficult marriage could be. He and his wife had separated more than once and he and his wife had been in marital counseling. (T. 40-41 [Patient A])

40. Patient A told Respondent that she was not having marital problems, that she was upset about the hysterectomy. Respondent told Patient A that he could understand her sadness, that at one time in his life he had contemplated suicide. (T. 40-41 [Patient A])

41. Respondent told Patient A that she was beautiful, that she was one of the most beautiful women he had ever seen. Respondent told Patient A that she had beautiful eyes and

46. After Respondent kissed and embraced Patient A and told her she was beautiful, she was shaken and trembling. She got off the examining table and went out of the room into the hallway. (T. 42-44 [Patient A)

47. Respondent followed Patient A. He stated he could see that she was shaken. He advised her to sit down and they could talk. (T. 42-44 [Patient A)

48. Respondent repeated he thought she was incredibly beautiful. He repeated he was very attracted to her, and that he knew that she must feel attracted to him too. (T. 42-44 [Patient A)

49. Respondent told Patient A that she seemed like she had always been "the good little girl," He told Patient A that "there are some things that [she] should just do for yourself." Respondent told Patient A that connections like the one he felt between her and himself only happen a few times in a lifetime. (T. 44-46 [Patient A])

50. Respondent was Patient A's physician. As a consequence of his role, Patient A trusted him and his comments had a significant impact on her. (T. 45-46 [Patient A])

51. Respondent reacted to Patient A's comments. He pulled Patient A's chair close to him and began kissing her and hugging her. He repeatedly told her that she was very tense and that she should just relax, that everything was okay. Respondent began to massage Patient A's neck. He told her that massages were very relaxing, very beneficial, and that

if she went back into the Examining Room, he would give her a massage. (T. 46-47 [Patient A])

52. Patient A went back into the Examining Room with Respondent. Respondent continued to massage her. While Respondent was massaging Patient A, he told her repeatedly that she was beautiful, that he loved the way she smelled, that he loved the way her skin felt, that it was "so soft." He told her how beautiful her eyes were, and took her face in his hands and stroked her face. (T. 46-47 [Patient A])

53. Patient A told Respondent that she really needed to leave. She again told Respondent that she was very confused. She told Respondent she needed to think about what he had told her. (T. 46-47 [Patient A])

54. Respondent asked her not to go. He told her he did not need to leave right away, and that he wanted to talk to her and get to know her and have her get to know him. (T. 46-47 [Patient A])

55. Patient A stayed, and they again sat in the chairs by the nursing station and talked. Eventually, Patient A got up to leave. Respondent showed Patient A where the bathroom was and followed her in. (T. 50 [Patient A])

56. There was a mirror over the bathroom sink. As Patient A stood at the sink, Respondent came behind her, put his head on her shoulder, and commented on what a beautiful couple he and Patient A would make. (T. 50 [Patient A])

57. Respondent told Patient A that she should take the medication he prescribed, and continue with the mineral oil enemas. Respondent gave Patient A his beeper number and told her that he was going to be on call all weekend and to call him any time. Respondent told Patient A to make sure that she called him the next day, particularly if she had not produced a bowel movement. (T. 50 [Patient A])

58. Patient A called Respondent the next day, which was Sunday, September 7, 1997, and told him that she still had not had a bowel movement. Respondent told Patient A to meet him at his office. (T. 51-52 [Patient A])

59. Patient A did so because she had an ongoing and uncomfortable medical condition that needed medical attention. (T. 51-52 [Patient A])

60. Patient A met Respondent at his office on Sunday, September 7. They went to the nursing station area where they had sat the previous day. Respondent asked her about her physical condition. (T. 52-53 [Patient A])

61. Respondent told Patient A that he hadn't meant to scare her the day before. Respondent stated he "knew" she felt the connection between them. Respondent stated that she was special to him. Respondent then began to kiss and hug Patient A again. (T. 52-53 [Patient A])

62. Patient A told Respondent that she didn't understand what was happening. Patient A stated she was struggling to understand what was taking place. She stated she thought it best if she left. (T. 53-54 [Patient A])

63. Respondent asked her not to leave. He told her he just wanted to look at her, to talk to her, and for them to get to know each other. (T. 53-54 [Patient A])

64. Respondent told Patient A that his wife was very ill, that she had non-Hodgkins lymphoma. (T. 54-55 63 [Patient A])

65. Respondent told Patient A numerous personal facts about his family:

    a. He had a daughter who had been a triplet;

    b. In the first trimester of the pregnancy, he and his wife had thought about separating, and had considered terminating two of the fetuses

    c. When he and his wife went to New York City to look into the procedure, they found that two of the fetuses had suffered fetal demise;

    d. Respondent told Patient A that his daughter had undergone brain surgery at some point. (T. 54-55 63 [Patient A])

66. Respondent kissed and hugged Patient A, and ran his hands through her hair. (T. 55-56 [Patient A])

67. Patient A went into the bathroom. Respondent came in, embraced her from behind, and told her they would make a beautiful couple. He told Patient A that he did not think her surgical scar was ugly at all, and asked her to show it to him. Patient A said she did not

want to, but Respondent kept whispering to her, "it's not gross. I just want to see it so you will see that it doesn't gross me out." Respondent unbuckled Patient A's belt and unfastened her jeans. He asked Patient A to pull up her shirt to show him the scar. She did. Respondent told Patient A that her scar wasn't gross, and that she was beautiful, perhaps the most beautiful woman he had ever seen. Respondent told Patient A that she was sexy. (T. 55-56 [Patient A])

68. Respondent asked Patient A to remove her pants. She refused. Respondent put his hands in her pants. He told Patient A that he wanted to "taste her." Patient A understood this to mean that he wanted to perform oral sex on her. (T. 60 [Patient A])

69. Patient A told Respondent that she was not going to allow Respondent to perform oral sex on her. (T. 60, 215 [Patient A])

70. Patient A was in a state of conflict over Respondent's proposition: On the one hand she was wearing a sanitary pad because she was still having some vaginal bleeding from her surgery; However, there was a part of her that was flattered. She thought Respondent must be sincere and care about her if he wanted to perform oral sex on her in the physical condition she was then in. (T. 60, 215 [Patient A])

71. Respondent put his hand inside Patient A's pants and put his finger in her vagina. Respondent then put his finger to his lips. (T. 60, 212-213 [Patient A])

72. Respondent asked Patient A to "taste him." She understood this to be a request to perform an act of oral sex on him. Respondent pulled down the pants of his surgical scrubs and asked Patient A to "taste him." Patient A kissed Respondent's penis. (T. 61)

73. Patient A noted that at the time of these events, Respondent did not have an erection. (T. 61)

74. Respondent told Patient A to sit down. Respondent noted that Patient A was obviously shaken. Respondent stated that she should not be driving in her condition. Respondent wrote another prescription for Patient A, and made small talk with her. (T. 61 [Patient A])

75. Patient A and Respondent spoke on the telephone several times early the following week. Respondent asked Patient A to meet him, that he missed her and just wanted to see her (T. 69 [Patient A])

76. Respondent again told Patient A numerous personal facts about his family. (T. 54-55 63 [Patient A])

77. Respondent asked Patient A to meet him for lunch at St. Clare's. Patient A did not want to meet at St. Clare's because she did not want to be seen with him. (T. 69 [Patient A], T. 964-965 [Respondent])

78. Patient A did not want to be the subject of rumors in the Hospital. (T. 69 [Patient A], T. 967, 971 [Respondent])

79. Patient A suggested they meet at the Plotterkill Preserve, which is a forest preserve with hiking trails near her home. (T. 69, 222 [Patient A])

80. On September 9 or September 10, Patient A drove to the Plotterkill Preserve. (T. 69-70, 222 [Patient A], T. 966-969 [Respondent])

81. Patient A arrived first in her own car. Respondent then arrived in his car. (T. 70 [Patient A]; T. 969-970 [Respondent])

82. Respondent asked Patient A to get into his car with him. (T. 223 [Patient A])

83. Respondent kissed and hugged Patient A and told her how much he had missed her. He told her she looked great and that she was a great dresser. (T. 70 [Patient A])

84. Respondent asked Patient A to recline the passenger seat in which she was sitting. Patient A said she did not want to lie down. Respondent reached over and reclined the seat himself. (T. 70 [Patient A])

85. Respondent stroked Patient A's face and told her how beautiful she was. He stated that people must tell her all the time how gorgeous she is, and that he had never seen eyes like hers. Respondent said that he wanted to get to know the person behind the beautiful brown eyes. (T. 70-72 [Patient A])

86. Respondent asked Patient A to unbutton her sweater. Patient A said she did not want to unbutton her clothing, particularly because another car had arrived. Patient A was

concerned that the owner of the car might return and see her with her sweater off. Respondent replied "he'll think you are the most gorgeous woman in the world and I'm the luckiest man." (T. 71 [Patient A])

87. Patient A and Respondent kissed and hugged for awhile. (T. 71)

88. Respondent's beeper had gone off twice, and Patient A said they should probably leave. Respondent used his car phone to return one of the calls, which was from Dr. Malebranche, the senior partner in Respondent's surgical practice. (T. 71-72)

89. Respondent escorted Patient A back to her car. He told Patient A that he was crazy about her, that he felt as though he were falling in love with her. (T. 72)

90. Respondent asked Patient A to accompany him to a medical conference he was going to that weekend in Rhode Island (T. 72 [Patient A],

91. Respondent attended a continuing medical education course in Rhode Island the weekend of September 12, 1997. (T. 1006 [Respondent])

92. Respondent asked Patient A to page him the following Monday, September 15, 1997. She did, but he did not respond.

93. The next day, Tuesday, September 16, 1997, Patient A again called Respondent from her home. Respondent returned her call. He told Patient A that he had been thinking

about her and about them while he was away. He told Patient A that he really wanted to see her and to talk to her in person. (T. 73 [Patient A])

94. Respondent suggested they meet at the Rotterdam Square Mall, which was near her house. Patient A did not want them to be seen together. (T. 74 [Patient A], T. 977 [Respondent])

95. Respondent suggested that the L&M Motel would be close to Patient A's home and would be private. Respondent told Patient A not to worry. Respondent had suggested a meeting at a motel because he just wanted to hold her. He told her that he knew she still was not feeling well. (T. 74 [Patient A])

96. Respondent told Patient A that he would go to the motel and check in first so that she would not be embarrassed. He would then call her with the room number. (T. 74-75 [Patient A], T. 981 [Respondent])

97. Respondent called Patient A back and told her the room number was 109. (T. 74-75 [Patient A], T. 981 [Respondent])

98. Respondent registered under a false name, using the name of a person he had trained with in New York City. Respondent put down a false address, in Mount Vernon, New York, which is near where Respondent trained in the South Bronx. (Pet. Ex. 13; T. 979-981 [Respondent], T. 1007, 1016 [Respondent])

99. Patient A drove to the L&M Motel to meet Respondent. When she went to Room 109, the door was slightly ajar. Respondent opened the door before Patient A could knock, and she entered the room. Respondent closed the door behind her and immediately began to passionately hug and kiss her. (T. 75-76 [Patient A] 979-81)

100. He told Patient A he had been thinking about her and how much he had missed her. He told Patient A how glad he was that she was there. (T. 75-76 [Patient A])

101. Respondent asked Patient A to sit with him on the bed. Respondent sat on the bed and motioned Patient A to sit next to him. Respondent had a suit on, and he told Patient A that he was going to remove his suit coat because he had a surgical case later at Ellis Hospital and he did not want to wrinkle his jacket. Respondent then said he would take off his shirt and tie because he didn't want them to be wrinkled. (T. 76 [Patient A])

102. Patient A sat on the side of the bed, and Respondent took hold of her shoulders and guided her back so that she was laying next to him. (T. 76) Eventually, both Patient A and Respondent were naked in the bed. (T. 76 [Patient A])

103. Respondent told Patient A he wanted to perform oral sex on her. Patient A was tense and uncomfortable. Patient A told Respondent she was still bleeding from the surgery and was wearing a sanitary pad. Respondent told her that he wanted to make her feel good, that women liked this. Respondent opened Patient A's legs and performed oral sex on her. (T. 77 [Patient A])

104. When Patient A remained very tense, Respondent stopped and said "You really don't like this?" When Patient A said she didn't, Respondent asked her "why, does it remind you of the family dog?" (T. 77, 233-234 [Patient A])

105. Respondent entered Patient A's vagina with his penis. Just before he did, Patient A asked Respondent if she should be engaging in coitus in her physical condition.(T. 78-79 [Patient A])

106. Patient A also asked Respondent if it was safe to have unprotected sex with him,. Respondent replied that he "didn't just do this with everyone," and that he was safe. (T. 78-79 [Patient A])

107. Respondent entered Patient A's vagina with his penis. After a short time, Respondent withdrew from Patient A. He told Patient A that something inside of her was causing him discomfort. (T. 79, 235 [Patient A])

108. Respondent put his fingers in Patient A's vagina and felt around and asked her if she felt a particular spot he was touching. He told Patient A that he felt suture material, and that must be what had caused the discomfort. (T. 79, 235 [Patient A])

109. Respondent began pushing his fingers in and out of Patient A's vagina. He told Patient A that he wanted to make her feel good, that he wanted to please her. He told Patient A that she was sexy and that she had a nice body. (T. 80 [Patient A])

110. Sexual intercourse, at this point in Patient A's recovery, would be contrary to accepted standards of medicine. (T. 987 [Respondent])

111. When the sexual activity was finished, Respondent began to talk about his personal life. He talked about his daughter. Respondent also told Patient A his father had died. (T. 80-81 [Patient A])

112. Patient A eventually got up and went into the bathroom of the motel room. She washed herself. When she came out of the bathroom, Respondent was dressed. He told Patient A that he had been paged, that his surgical case was ready and he needed to leave. (T. 81)

113. Just before Respondent left the room, he told Patient A that she should have someone look at the beauty mark on the inside of her thigh. (T. 81 [Patient A])

114. Later, in the afternoon on September 16, 1997, Respondent called Patient A at home. He told her she should douche to get rid of the suture material in her vagina. (T. 81-82 [Patient A])

115. Following the encounter on September 16, 1997, at the L&M Motel, Patient A continued to call Respondent for a period of time during September 1997. When Respondent returned her calls, he would tell Patient A that he was busy and couldn't talk. (T. 83 [Patient A])

116. Patient A kept calling for a period of time because she did not want to believe that Respondent had used her and discarded her. Patient A did not want to believe that Respondent had taken advantage of her sexually. She wanted to believe the things Respondent had told her before were true. (T. 82-83 [Patient A])

117. Patient A's final post-surgical medical appointment with Respondent was scheduled for October 2, 1997. She had intended to cancel her October appointment.

118. However, prior to October 2, Patient A had gone hiking and experienced pain and rectal bleeding. Patient A called Respondent's office. Her appointment was moved up to September 30. (Pet. Ex. 4; T. 85-87 [Patient A])

119. Patient A was seen by Respondent in his office for medical care on September 30. (Pet. Ex. 4; T. 85-87 [Patient A])

120. Patient A would not have returned to Respondent for medical care. However, the pain and rectal bleeding she experienced required medical attention by her then treating physician. (Pet. Ex. 4; T. 85-87 [Patient A])

121. In late September or early October 1997, Patient A told her supervisor [redacted] the sexual details of her relationship with Respondent. (T. 444-451 and 453 [redacted]), T. 166-169, 236-237, 245 [Patient A])

122. On or about October 14, 1997, Patient A told Dr. Etkin, that she had had sexual encounters with Respondent, and that they had had sexual intercourse. Dr. Etkin was Patient A's gynecologist and it was he who had referred her to Respondent (T. 427-428 [Etkin], T. 87-88 [Patient A])

123. Patient A was depressed and very agitated when she told Dr. Etkin what had occurred. She expressed shame about what had happened. (T. 427 [Etkin])

124. Patient A told Dr. Etkin that the sexual intercourse with Respondent was unprotected. (T. 88) Dr. Etkin tested Patient A for sexually transmitted diseases. (Pet. Ex. 5)

125. Dr. Etkin made entries in Patient A's medical record recording what she said about her experience with Respondent. (Pet. Ex. 5; T. 428, 438-439 [Etkin], T. 88-89 [Patient A])

126. Dr. Etkin told Patient A that he had another patient whom he had previously referred to Respondent. The other patient stated she had had an experience with Respondent similar to that described by Patient A. (T. 430-431 [Etkin], T. 89-96 [Patient A])

127. Patient A wanted to speak to this other patient. (T. 96-97 [Patient A], T. 430 [Etkin]) Dr. Etkin told Patient A that he could not give her the patient's name. Patient A told Dr. Etkin that he could identify Patient A to the other patient in an effort to see if the other patient was willing to speak to Patient A. (T. 96-97 [Patient A], T. 430-431 [Etkin])

128. Dr. Etkin spoke to the other patient and gave her Patient A's name and telephone number. (T. 430-431 [Etkin])

129. Patient A received a telephone call from the other patient. The other patient referred to by Dr. Etkin is the person identified as Patient B in this proceeding. Patient A and Patient B did not know each other prior to the efforts of Dr. Etkin to introduce them. (T. 96-97 [Patient A])

130. Respondent engaged in sexual intercourse with Patient A less than one month after she had undergone major surgery. (Pet. Ex. 4; see T. 78-80 [Patient A])

131. Sexual intercourse less than a month after the surgery Patient A had undergone is unsafe and poses risks to the patient. (T. 987, 1059-1060 [Respondent])

132. Generally accepted standards of care require that patients wait six weeks before engaging in sexual intercourse. (T. 947 [Respondent])

133. If a patient has sexual intercourse less than four weeks after such surgery, there is a risk of infection.

Conclusions
With Regard to
Factual Allegations
Arising From
the Care and Treatment
of
Patient A

In Factual Allegation A, Respondent is charged with four separate events constituting the assertion he had a sexual relationship with Patient A during the period of time when he was treating her as a surgical patient. Respondent admits he provided medical treatment to Patient A as described in the Statement of Charges. Respondent also admitted he had a special friendship with Patient A that went beyond mere medical treatment. However, he denies any intimate contact or sexual conduct of any kind. Respondent states he tried to be a caring practitioner for Patient A who was ill from and distraught over a very recent hysterectomy.

It is undisputed that at the time of the incidents alleged, Patient A was suffering extreme emotional stress arising from having undergone a hysterectomy. She was a young, married woman. She and her husband wanted a large family. At the time of the hysterectomy, she and her husband had not yet had any children. The surgery meant that she would never be able to conceive a child.

In addition to the concern that she would be unable to fulfill the desire she and her husband had for children, she was concerned that the scars from the surgery would make her unattractive to her husband. As the events unfolded she was also deeply troubled over the idea that the hysterectomy was not even necessary. In short, she was an attractive woman who, at the time of the events reported was extremely vulnerable. She shared some of her most private concerns with Respondent as a result of and within the context of the medical treatment he provided for her.

To meet its burden of proof, the State must establish by a preponderance of the evidence, that Respondent indeed had the relationship with Patient A as set forth in Factual Allegations A(1) through A. (4[2]). It is noted by the Trier of Fact that Respondent would have this

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[2] As is always the case in a matter before the Board For Professional Medical Conduct, the Trier of Fact must first assess whether the facts alleged have been proven. Upon establishing the truth of any of the

body believe Patient A fabricated the encounters she described. Respondent admits he had a special friendship with Patient A but that the extent of their relationship was limited solely to personal conversations of a medical, as well as a non-medical nature.

During the vast majority of the encounters set forth in the charges and recited by Patient A, there were only two people present: Respondent met Patient A in secluded areas. He also met her in areas of the hospital and on days where and when there were virtually no other people present. Therefore, the Factual Allegations herein will rise or fall based solely upon the credibility of Respondent versus Patient A.

The Committee is convinced, to a standard greater than mere preponderance, that Patient A reported the truth and that the Factual Allegations in the charges are true. In concluding that Patient A was being truthful and Respondent was not, the Committee relied primarily upon the presentation of the testimony by Patient A. The Committee found Patient A to be entirely credible. Her testimony was delivered without apparent hostility and without any suggestion of a vendetta or other personal agenda. Patient A described her acts as a married woman who had engaged in adultery. She made no excuses for her behavior. She did not try to avoid personal responsibility for her part in the activities.

Neither the charges, nor Patient A in her testimony, alleged the use of force by Respondent. Clearly, Respondent engaged in intense seduction, but it is equally clear that Patient A participated in the encounters with little more than modest verbal objection.

Patient A was subjected to extensive and aggressive cross examination. While some inconsistencies and apparent errors arose in her testimony, they were minor when compared to the totality of her statement. Patient A presented her answers during direct and cross

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facts, the Committee will then turn its attention to whether the facts proven constitute medical misconduct.

examination in a decorous and non-hostile manner. Given the extraordinarily personal facts in her recitation, she occasionally displayed emotion and difficulty in providing answers to questions. However, the level of difficulty and emotion she displayed were at levels that appeared, to the Trier of Fact, to be appropriate to her situation. Any hesitation or difficulty she demonstrated appeared entirely genuine and without artifice. Indeed, Patient A made no effort to sway the Trier of Fact with emotional outbursts or displays. She presented the facts, without significant characterization and without histrionics or questionable demeanor. The statements presented by Patient A had a logical progression and made sense in their context. That is, if a physician and a person such as Patient A were going to have an affair, the progression from flirtation to sexual contact had the ring of truth.

The Committee also considered that Patient A had virtually nothing to gain from coming forward and providing testimony in this proceeding. It is unlikely that seduction by a physician would lead to monetary damages if a suit were brought. In addition, it did not appear that Patient A had any direct desire to ruin Respondent. The overall tone of her testimony was one of a woman who simply wanted the facts to be known. Compared to the lack of potential reward for her testimony, Patient A had very much to loose by publicly making her statements as presented herein. Her testimony publicized acts of adultery in which she participated. As a married woman, Patient A might reasonably have chosen to be silent about the events she reported for the sake of her marriage. Whatever the present nature of her relationship with her husband, the admissions she made in her testimony surely put a significant strain on her relationship with both her husband and her entire family.

For his part, Respondent had much to lose by admitting the sexual acts set forth in the charges. Respondent knew that the allegations presented herein, if true, could ruin his reputation as a surgeon in his office, St. Clare's hospital community, as well as in his home community. As

a married man with children, the accusations in this proceeding, if sustained, would bring enormous negative consequences to his family. Indeed, his entire career might well be ruined at an early age.

In addition to having very strong motives to deceive the Trier of Fact herein, Respondent lost his credibility with the Trier of Fact early on by virtue of various admissions. The most significant admission made by Respondent was that he went to the L & M Motel on September 16, 1998 to meet Patient A. (see Tr. p. 980 ff.). Respondent would have the Trier of Fact believe that he went to the motel merely to speak privately with Patient A; that he paid for the room in cash; that he registered under an assumed name; and that he went to the room but left the motel before Patient A arrived. The Trier of Fact makes two findings based upon Respondent's admissions about the L & M Motel: First of all, contrary to Respondent's assertions, Patient A could not have entirely fabricated her testimony about a sexual relationship with Respondent. The fact that Respondent admits he went to a motel to meet Patient A clearly establishes that, at the very least, the basic outline of an intense, other-than-medical, relationship existed between Respondent and Patient A. Two married adults simply do not plan to meet at a motel for licit purposes. Second, given all the benefit of doubt that an accused is entitled to, it utterly defies credulity that a person such as Respondent would go to a motel, register under an assumed name, pay for the room in cash, go to the room, and then, at the last minute, find his conscience and leave prior to meeting his intended partner. Such an assertion flies in the face of logic and human experience.

While unnecessary to reach their conclusion, the Committee also refers to the admission by Respondent that he met Patient A at the Plotterkill Preserve. Like the admissions about the motel, this admission also acts to destroy Respondent's assertion that Patient A fabricated her allegations. Furthermore, the progression from a quiet park to a motel makes sense in the overall

scheme of human events of this nature. Where married adults are planning to engage in an illicit affair, it makes sense that the privacy of the meeting places would slowly rise until absolute privacy was obtained. Respondent's assertions, that he agreed to meet Patient A at a motel simply to talk, are inconsistent with common sense and the fundamental logic of human relationships.

Having found Patient A not just more credible than Respondent, but rather, having found Patient A to be truthful and Respondent dishonest, the Committee therefore finds that the factual allegations set forth in the Statement of Charges are true and must be sustained.

Therefore:

Factual Allegation	**A**	**IS SUSTAINED;**
Factual Allegations	**A (1.) (a) through A (1.) (f)**	**ARE SUSTAINED;**
Factual Allegations	**A (2.) (a) through A (2.) (i)**	**ARE SUSTAINED;**
Factual Allegations	**A (3.) (a) through A (3.)(c)**	**ARE SUSTAINED;**
Factual Allegations	**A (4.) (a) through A (4.)(e)**	**ARE SUSTAINED;**

Findings of Fact Arising From the Care and Treatment of Patient B

1. Patient B, a 32 year old married woman, was referred to Respondent by her obstetrician and gynecologist, Dr. Richard Etkin, for a varicose vein on the back of her left leg. (Pet. Ex. 9; T. 258-259 [Patient B])

2. Patient B's first visit to Respondent's office for medical care was March 13, 1997. She was seen at Respondent's office at St. Clare's. (Pet. Ex 9; T. 259)

3. On May 15, 1997, Respondent performed surgery on Patient B at St. Clare's. (Pet. Ex. 9; T. 264 [Patient B] T. 264-265 [Patient B])

4. Patient B was scheduled to see Respondent for a post-operative office visit on Thursday, May 22, 1997. A few days prior to Patient B's appointment, on approximately Tuesday, May 20, 1997, Respondent called Patient B at her home. Respondent asked Patient B why she had not been in to the office for her post-op checkup. Patient B responded that he had told her to come in one week from the day of the surgery, that it was only Tuesday, and her appointment was not until Thursday. (T. 265-266 [Patient B])

5. Respondent then asked Patient B how she was doing and how things were going, and they had a conversation. Respondent mentioned during that conversation that he was stressed, that there were stressful things in his personal and professional life. (T. 265-266, 322-325, 329 [Patient B])

6. On more than one occasion prior to this call on or about May 20, 1997, Respondent had made telephone calls to Patient B at her home following her appointments for medical care at Respondent's office. (T. 261-263, 317, 325-326 [Patient B])

7. Respondent would initiate these calls, and would introduce himself by saying "This is Steve." He would pause, and then add "St. Lucia." During these conversations, Respondent would ask Patient B how she was. He asked her about her leg vein, and then asked how she was in general, and how things were going. (T. 261-263, 317, 325-326 [Patient B])

8. After a visit on which Patient B was seen for her rib pain, Respondent called her at home and asked her if he had hurt her while he was examining her. He again asked Patient B how she was doing in general, how things were going. (T. 261-263, 317, 325-326 [Patient B])

9. Patient B went to Respondent's St. Clare's office for her post-operative visit on May 22, 1997. Patient B was wearing a tan sleeveless shirt and black flowered wrap around skirt. On that visit, Patient B was brought to the examining room by a nurse, who then left the room. Respondent then entered. The nurse re-entered the room at some point for a few minutes and then left again. For most of the visit, Respondent and Patient B were alone in the room. (T. 266, 331-332 [Patient B])

10. Respondent told Patient B that he liked her skirt, and said "I like that skirt and it opens," or words to such effect. (T. 267-268, 331-332 [Patient B])

11. Respondent examined Patient B's leg and then asked her to lay on her stomach on the examining table. Respondent commented about a mole Patient B had on her left ankle, then began to touch the lower part of her leg. (T. 269, 333 [Patient B])

12. Patient B asked Respondent about giving a massage. Respondent replied "I give a great massage. Sometime you might want to have one. Sometime I might give you one", or words to such effect. When Respondent made these comments, Patient B understood him to be flirting with her. (T. 269, 333 [Patient B])

13. When Respondent concluded his physical examination of Patient B she sat up on the examination table and swung her legs around the side of the table to get up. Respondent then reached over and closed up Patient B's skirt. (T. 269, 333 [Patient B])

14. After closing up Patient B's skirt, Respondent sat very close to her and began to talk with her. Respondent was alone with Patient B. Respondent told Patient B that she had very beautiful brown eyes and that he enjoyed her company. Respondent talked about his daughter, and Patient B spoke of her children. Respondent told Patient B that he was very stressed, that a lot of things were going on in his life, and he just needed someone to talk to about things. He said that Patient B made him feel very comfortable. (T. 270, 335-336 [Patient B])

15. At the conclusion of his conversation with Patient B, Respondent, told her that her next appointment would be in one month. (T. 270-271 [Patient B])

16. Respondent's note for Patient B's May 22 office visit stated that "follow-up will be in one month to determine the presence of any collaterals which we may sclerose in the office."

17. When Respondent told Patient B that her next appointment would in one month, Patient B said "I have to wait a whole month before I come back?" (T. 270-271, 337, 340 [Patient B])

18. Patient B wanted to see the results of her surgery. She was also flattered by the attention that Respondent was paying to her. (T. 270-271, 337, 340 [Patient B])

19. Respondent told Patient B "I would bring you in every day if I could." (T. 271 [Patient B])

20. After Patient B left Respondent's office on May 22, she was thinking about the things that Respondent had said to her that day:

    a. She believed that Respondent was overtly flirting with her;
    b. she wanted to know if that was what was actually happening;
    c. She decided that she would call him and ask him directly.(Pet. Ex. 22; T. 271-272, 337 [Patient B])

21. When she arrived home, she called Respondent's office and left a message for him to call her. (Pet. Ex. 22; T. 271-272, 337 [Patient B])

22. Patient B told her mother that if Respondent called when she was not at home to ask him to call the following morning. Respondent did call the next morning. Patient B's husband was still at home. (T. 271-272 [Patient B])

23. Respondent said, "Hi, this is Steve. Is this a good time?" Patient B said it was not. Respondent said he would call back in a little while. Patient B lied to her husband about who had called. (T. 271-272 [Patient B])

24. Patient B and her husband were having marital problems at the time. She was in a vulnerable state. She was flattered by the attention and compliments from Respondent. (T. 273, 338-340 [Patient B]).

25. Respondent called Patient B back sometime later on the morning of May 23. Patient B said she wanted to talk to him about her office visit of May 22. Patient B asked Respondent if he was flirting with her. Respondent admitted he was. (T. 273-274 [Patient B])

26. Respondent told Patient B he did not mean to make her feel uncomfortable. Patient B said she did not, she just wanted to know if that was what was happening. (T. 273-274 [Patient B])

27. Respondent again told Patient B how much he enjoyed her company, her eyes and her smile, and told her that he was going through a difficult time. He said that he was very stressed at work and at home; that he just needed someone to talk to about things. (T. 273-274 [Patient B])

28. Patient B and Respondent agreed that they would get together the following week, on approximately May 27, a day when Respondent was on call. (T. 273-274 [Patient B])

29. On the morning of May 27, Patient B began to feel sick and conflicted about agreeing to meet Respondent. She considered it wrong to be meeting him secretly. She had not conducted herself this way in her marriage. (T. 274-275 [Patient B])

30. She took the phone off the hook for several hours in an effort to avoid his call. (T. 274-275 [Patient B])

31. Later that morning, she put the phone back on the hook, and Respondent called her. Respondent asked Patient B if they were going to meet. Patient B said she didn't know if she could do this. She told him she was feeling upset with herself for even thinking about a liaison. (T. 274-275 [Patient B])

32. Respondent told Patient B: "It sounds like what you need is a doctor." They discussed whether she would meet with him or not. (T. 274-275 [Patient B])

33. On or about May 29, two days after her conversation with Respondent, Patient B spoke to her husband about her complicity with Respondent:

    a. She told her husband that Respondent had been flirting with her and that she had been flirting in return;

    b. She told her husband she was sorry for her behavior.

34. Patient B's husband asked her to call Respondent and end the matter. She agreed to tell Respondent not to call anymore. (T. 275-276, 339-342 [Patient B])

35. Patient B called Respondent the next day, and left a message. When Respondent called her back, Patient B told him she didn't think she should see him. Respondent said he was not pushing her, but that he really did want to talk. Patient B and Respondent spoke on the phone the next day as well. (T. 277-278 [Patient B])

36. Respondent had given Patient B his beeper number. He had told her any time she wanted to get in touch with him, she should call his service and tell them she had a question about her leg vein. (T. 277-278 [Patient B])

37. On Sunday, June 1, Patient B paged Respondent. Respondent called Patient B back, and they had a brief conversation. Patient B told Respondent she would meet him that day at his office at St. Clare's. (T. 277-278 [Patient B])

38. Patient B drove to Respondent's office at St. Clare's. Respondent met Patient B by the check out desk. He and Patient B proceeded to an examination room across from Respondent's office. (T. 277-278 [Patient B])

39. Respondent and Patient B sat in the examination room and began to talk about personal problems. (T. 277-278 [Patient B])

40. Respondent was sitting on a chair with wheels and wheeled himself close to Patient B. Respondent began touching Patient B's hands and commented she had nice hands. Respondent then brought Patient B to a standing position. He, hugged her, and kissed her on her mouth. Respondent and Patient B kissed for a long time. (T. 279-280, 361-362 [Patient B])

41. Following her meeting with Respondent on June 1, Patient B had growing personal feelings for Respondent. She began to believe she was falling in love with him. (T. 362 [Patient B])

42. Approximately a week or a week and half after Patient B met Respondent at his office, they again spoke by telephone. They agreed to meet the weekend of June 14, when Respondent would be on call.. (T. 282-283 [Patient B])

43. On June 14, Patient B attended a wedding. She then paged Respondent. Respondent called back, and Patient B told him she could come to his office then. They agreed to meet at Respondent's office at St. Clare's.. (T. 282-283 [Patient B])

44. Patient B drove to Respondent's office. Respondent was waiting outside the building. He told Patient B that she looked great and he loved her style. Patient B was still dressed for the wedding she had attended. She was wearing a black dress with flowers on it. (T. 282-283 [Patient B])

45. Patient B and Respondent entered the building and took the elevator to Respondent's office. Respondent unlocked the door, and they entered the office. (T. 282-283 [Patient B])

46. Respondent took Patient B to a room off the same hallway as his office and the examining room they had been in on June 1. Patient B noticed a table and chairs in the room. She thought it to be a break room for staff. (T. 282-283 [Patient B])

47. Respondent and Patient B sat down and talked briefly. They soon began to kiss. Respondent and Patient B stood up and continued to kiss. Respondent started to lay Patient B down on the table. The table was not stable enough for this maneuver. (T. 282-285, 367-368 [Patient B])

48. Respondent then took Patient B into an examining room. Respondent and Patient B kissed. Respondent brought Patient B to a sitting position on the examining table. The table could be raised or lowered in height. Respondent moved the examining table higher. (T. 282-285, 367-368 [Patient B])

49. Respondent tried to remove a foundation garment that Patient B was wearing under her dress. He had some difficulty doing so. Patient B removed the garment. She did not remove her dress. Respondent kissed and touched Patient B. (T. 282-285, 367-368 [Patient B])

50. Respondent performed oral sex on Patient B. (T. 282-285, 367-368 [Patient B])

51. After Respondent performed oral sex on Patient B she reached out and touched Respondent's crotch. Respondent was wearing surgical scrubs. When Patient B touched Respondent, she was surprised to find that he did not have an erection. (T. 282-285, 367-368 [Patient B])

52. Patient B put her control garment back on, and she and Respondent kissed some more. Eventually, they had to leave. Respondent told Patient B he had to go to surgery. (T. 282-285, 367-368 [Patient B])

53. In late August 1997, Patient B spoke to Dr. Etkin about her experience with Respondent. Dr. Etkin had been her OB-GYN since 1991.. He had referred her to Respondent. (T. 296-297 [Patient B], T. 402-403 [Etkin])

54. Dr. Etkin has an office in Clifton Park, the town where Patient B resides. Patient B stopped by that office and asked if she could speak with Dr. Etkin. (T. 258, 296-297 [Patient B], T. 400 [Etkin])

55. Dr. Etkin met with Patient B and spoke with her. Patient B disclosed she had had an illicit relationship with Respondent. She told Dr. Etkin:

    a. She was upset about her experience with Respondent;

    b. She was upset over the relationship he had commenced with her;

    c. She was upset over the manner in which he had treated her. (T. 297-298 [Patient B], T. 403-404 [Etkin])

56. Dr. Etkin was the physician who had referred her to Respondent. Patient B thought he should know what had happened.

57. She trusted Dr. Etkin. She had had a long physician-patient relationship with him. She wanted his advice regarding what he thought she should do about what had happened. (T. 296-297 [Patient B])

58. At a subsequent visit by Patient B to Dr. Etkin for medical care, Dr. Etkin told Patient B that another patient had had a similar experience with Respondent. (T. 298-299 [Patient B], see T. 430-431 [Etkin])

59. Dr. Etkin told Patient B that the other patient wanted to meet her and speak with her. Dr. Etkin asked Patient B if she would speak to the other patient. Patient B said that she would. Dr. Etkin arranged for Patient B to obtain the phone number of the other patient. (T. 298-299 [Patient B], see T. 430-431 [Etkin])

60. Patient B went home and phoned the other patient. The "other patient" was the person referred to in this proceeding as Patient A. (T. 298-299 [Patient B], see T. 430-431 [Etkin])

61. Patient A met Patient B and spoke to each other about their experiences with Respondent. Patient A did not reveal all the details of her experience to Patient B. (T. 300-301 [Patient B], T. 96-97 [Patient A])

62. Patient A and Patient B did not know each other prior to the intervention by Dr. Etkin. (T. 96-97 [Patient A], T. 298-299 [Patient B])

Conclusions With Regard to Factual Allegations Arising From the Care and Treatment of Patient B

In Factual Allegation B, Respondent is charged with four separate events constituting the assertion he had a sexual relationship with Patient B during the period of time when he was treating her as a surgical patient. Respondent admits he provided medical treatment to Patient B as described in the Statement of Charges. However, he denies any intimate contact or sexual conduct of any kind. Respondent asserts that like Patient A, Patient B fabricated all aspects of the other-than-medical contact she reported.

There are many parallels between the allegations associated with Patient A and those associated with Patient B. Both sets of accusations involve adulterous extra-marital affairs. Most important, both sets of accusations rely primarily upon the credibility of the accuser since no one else was present when the events took place.

Where a Trier of Fact decides that a witness has not told the truth about material facts, that finding can be applied to other testimony particularly where the other testimony is parallel to the first. In this case, the Trier of Fact has found that Respondent lied about his relationship with Patient A. It therefore follows that it is highly likely he would lie about his relationship with Patient B. The combination of Respondent's status as a prevaricator, when coupled with the credibility

of Patient B leads the Trier of Fact to conclude, to a standard greater than mere preponderance, that Patient B told the truth and that the Factual Allegations in the charges are true.

In concluding that Patient B was being truthful and Respondent was not, the Committee relied primarily upon the personal credibility of Patient B as measured during the presentation of her testimony. The Committee found that Patient B was entirely credible. Her testimony, like that of Patient A, was delivered without substantial hostility and without the appearance of a vendetta or other personal agenda. Again, like Patient A, Patient B described her acts as a married woman who had engaged in adultery. She did not try to avoid personal responsibility for her part in the activities. It is to be noted that there was no hint of the use of force by Respondent. Patient B was a willing participant in the encounters.

Again, like Patient A, Patient B was subjected to extensive and aggressive cross examination[3]. While some inconsistencies and apparent errors arose in her testimony, they were minor when compared to the totality of the facts presented. Patient B responded to questions during direct and cross examination in a decorous and essentially non-hostile manner. Given the extraordinarily personal facts in her recitation, she occasionally displayed emotion and difficulty in providing answers to questions. However, the level of difficulty and emotion she displayed were at levels that appeared, to the Trier of Fact, to be appropriate to her situation. Any hesitation or difficulty she demonstrated appeared genuine and without artifice. Patient B made no effort to sway the Trier of Fact with emotional outbursts or displays. She presented the facts, without significant characterization and without histrionics or questionable demeanor.

In finding Patient B credible, the Committee again considered that Patient B had virtually nothing to gain from coming forward and providing testimony in this proceeding. Her testimony

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[3] Unlike Patient A, there was no reference to information which was unavailable to Respondent.

made acts of adultery public. As a woman who was married at the time of the events, Patient B might reasonably have chosen to be silent about the events she reported for the sake of her reputation. Likewise, there is virtually no direct reward that could come to Patient B from her testimony herein. On the other hand, as stated previously, Respondent had much to lose by admitting the sexual acts set forth in the charges.

Having found Patient B not simply more credible than Respondent, but rather, having found Patient B to be truthful and Respondent a prevaricator, the Committee therefore finds that the factual allegations set forth in the Statement of Charges are true and must be sustained.

Therefore:

Factual Allegation	**B**		**IS SUSTAINED;**
Factual Allegations		**B (1.) (a) through B (1.) (d)**	**ARE SUSTAINED;**
Factual Allegations		**B (2.) (a) through B (2.) (f)**	**ARE SUSTAINED;**
Factual Allegations		**B (3.) (a) through B (3.)(g)**	**ARE SUSTAINED;**
Factual Allegations		**B (4.) (a) through B (4.)(c)**	**ARE SUSTAINED.**

Findings of Fact Arising From the Care and Treatment of Patient C

1. Patient C saw Respondent for medical care in June 1997. Patient C was thirty years old. Patient C had had multiple breast biopsies in the past. She was very concerned about cancer. Her mother had been diagnosed with cancer at age 31. She had eventually died from that disease. Patient C feared that because she and her mother shared a similar medical history, she would get breast cancer and die, leaving her own children without a mother. (T. 576-577 [Patient C])

2. Respondent examined her and found thickening and cystic changes in her left upper quadrant. She was referred for a mammogram and ultrasound. (Pet. Ex. 10, p. 38; T. 577-579 [Patient C])

3. Patient C asked Respondent about genetic testing. She had heard such testing was possible. She wanted to know more about it. Respondent was supportive of the idea and made some initial efforts with regard to setting up the testing. (Pet. Ex. 10, p. 38; T. 577-579 [Patient C])

4. Beginning at the end of June 1997, Respondent and Patient C were having frequent telephone conversations. She had noticed that their relationship was becoming less formal and more casual. It became a more personal and friendly relationship,. (T. 579-580 [Patient C], T. 1416-1417 [L. Martin])

5. Respondent and Patient C began to have conversations that were not related to medical care. (T. 580)

6. Respondent began to show a personal interest in Patient C. Patient C began to consider Respondent her friend. (T. 673 [Patient C], T. 1416-1417 [L. Martin])

7. Respondent had spoken to Patient C during an office visit about her cigarette smoking in relationship to her medical care issues. (Pet. Ex. 10; T. 581 [Patient C])

8. Respondent had told Patient C that she needed to cease smoking. She was told this would reduce her discomfort from her fibrocystic breasts. Respondent also told her she might not be accepted for genetic testing if she were a smoker. (Pet. Ex. 10; T. 582 [Patient C])

9. At some time during the Summer of 1997, Respondent entered into a bet with Patient C about whether or not she could stop smoking. The terms were:

   a. If Patient C was successful in quitting smoking, Respondent would go with her for the evening and do whatever she wanted to do;

   b. If Patient C did not stop smoking, Respondent would take her for himself and do whatever he wanted with her for an evening.

   c. Respondent said that Patient C was "his for the night" if she lost the bet. (T. 646-647 [Patient C])

10. Respondent's meaning was sexual in nature: If Patient C lost the bet she would be expected to have sex with him. (T. 583-583, 646-647 [Patient C])

11. After Patient C told Respondent that she had not been able to quit, and had begun smoking again, Respondent said to her "You're not going to welsh, are you?"

12. In his question, Respondent was asking Patient C if she was going to back out of their bet now that he had won? Patient C told him she was not. (T. 646-647 [Patient C])

13. When Respondent and Patient C discussed the bet about her quitting smoking, Patient C told Respondent she wasn't really worried if she lost because "he [Respondent] was kind of old and she didn't think he could handle her." (T. 584-585 [Patient C])

14. Patient C knew that Respondent was approximately 10 years older than she was. Respondent's reply was to tell Patient C that she "didn't know what she was in for."

15. In these remarks by Respondent he meant he was talented sexually and was not too old. (T. 584-585 [Patient C])

16. During a telephone conversation between Respondent and Patient C in the Summer of 1997, Respondent and Patient C again discussed her smoking. Respondent told Patient C that they "needed to find a different type of oral fixation for her." When Patient C asked Respondent what he meant by that, Respondent indicated that a description would be inappropriate to be stated as he was then in his office. (T. 583, 642-243 [Patient C])

17. Respondent's meaning was: Patient C's "new oral fixation" should be performing oral sex on him. (T. 583, 642-243 [Patient C])

18. On Monday, July 28, 1997, Respondent performed biopsies of Patient C's right shoulder, left thigh and right knee. (Pet Ex. 10; T. 587-588 [Patient C])

19. Patient C had some problems with the incision in her knee. It was a small incision, but it had split open and was infected. Patient C called Respondent and asked him if he wanted to look at it. He suggested that she come to his office that Saturday morning. (T. 587-589, 641-638 [Patient C])

20. On Friday evening, Respondent called Patient C at her home, and they talked about meeting at his office the following morning. The conversation had sexual overtones.

While the meeting at Respondent's office the following morning was ostensibly for the purpose of Respondent treating Patient C's knee, it would really be a meeting for intimate contact between Respondent and Patient C. (T. 587-589, 641-638 [Patient C])

21. Patient C was at a very low point in her life. Patient C was thrilled that someone of Respondent's stature, a physician, was interested in her on an intimate level. (T. 637 [Patient C], T. 1417-1418 [L. Martin])

22. On Saturday morning, August 2, 1997, Patient C met Respondent at his office at St. Clare's. Respondent met Patient C outside the building, then took her inside and upstairs to his office.

23. Respondent's office was locked and the lights were off. Respondent used his key to open the door. Respondent and Patient C entered and went to an examining room. Patient C sat on an examination table. (T. 590-591 [Patient C])

24. Respondent's beeper went off, and he went outside the door of the examining room to make a phone call. Respondent came back into the office with the phone, stretching the phone cord from the phone outside into the office. Respondent was talking on the phone with his associate, Dr. Rebenal. (T. 590-591 [Patient C])

25. While he was on the phone, Respondent went to a cabinet and took out a needle. When Patient C saw the needle, she became nervous. Respondent ended his phone conversation. He told Patient C that the needle was for lidocaine for her infected knee.

Respondent treated Patient C's knee. They engaged in conversation. (T. 590-591 [Patient C])

26. Respondent talked with Patient C about how anxious and stressed she was:

    a. She was obsessed with the idea that she would get breast cancer and die young as her mother had;

    b. She was obsessed with having genetic testing and knowing the results.

    c. Her job was stressful;

    d. It was hard to juggle her job and raise three children;

    e. Sometimes it was hard to cope (T. 591-592, 569-571, 652 [Patient C])

27. Respondent expressed concern about how stressed Patient C was. He told her that some years before he had been in the same situation. He let the stress in his life consume him. Respondent told Patient C that he finally took stress relaxation classes and learned how to relax. Respondent told Patient C that he was going to help her to be that great, fun person that he knew was inside her. He said he knew she could be a fun person, but she had to let go of her stress. (T. 652 [Patient C])

28. At the time of this conversation, Patient C was sitting on an examination table. She was moving her feet in a nervous manner. Respondent took hold of her feet to stop her from moving them. Respondent began to massage Patient C's feet. Gradually he moved to other parts of her body. He massaged her legs, neck, back, head, face and arms. Respondent told Patient C that he was relaxing her. (T. 591-593 [Patient C])

29. During this massage, Respondent began to kiss Patient C. Respondent started by kissing Patient C's forehead. He moved down the bridge of her nose, around her lips, and then on her mouth. (T. 591-593, 648-651 [Patient C])

30. Respondent had his hand on Patient C's leg. Respondent began to move his hand up her leg. He then put his hand under the leg of her jean shorts, against her skin. He moved his hand to her upper thigh and groin area. When Respondent did this, Patient C became nervous and sat up again. Respondent stopped. (T. 593-594, 653-654 [Patient C])

31. Patient C asked Respondent if he relaxed all his patients this way. Respondent sat back, crossed his arms, and told Patient C "No, not at all. I really like you." (T. 594 [Patient C])

32. Respondent told Patient C that he thought she was a good person, and he found her very funny. Respondent told Patient C that he felt comfortable with her and being with her. (T. 594 [Patient C])

33. Following the August 2 meeting in Respondent's office, Respondent and Patient C continued to speak by telephone. Patient C spoke to Respondent on or about Thursday, August 14. She inquired about an article he had given her about genetic testing. She also mentioned that her knee was still not healing. Respondent told her to meet him on Saturday morning. (T. 597 [Patient C])

34. Patient C went to Respondent's St. Clare's office on the morning of Saturday, August 16. Patient C remembered that it was the weekend of the Altamont Fair. [redacted] (T. 596-597 [Patient C])

35. Respondent met Patient C. He took her up to his office. He unlocked the office door with his key, and they went to an examination room. Patient C sat on an examination table, and Respondent examined her knee. He said it was not healing correctly, and he cleaned it out and put a band-aid on it. (T. 596-597 [Patient C])

36. Patient C asked Respondent questions about the genetic testing. She asked him if he were in her position, would he have it done? Respondent said he would. (T. 598-600 [Patient C])

37. Respondent kissed Patient C on the mouth. Patient C told Respondent that she needed help with the genetic testing and she had concerns about it. She told Respondent that kissing was not going to accomplish what she needed. (T. 598-600 [Patient C])

38. Respondent became angry. He told Patient C "I'm not a fucking psychiatrist; I'm a fucking surgeon." He told Patient C that she had no medical degree, no medical background, and that she didn't have a clue what she was talking about. He told her that she just needed to "chill out, go down there and have the test, and then deal with whatever happened." (T. 600, 657, 659-660 [Patient C])

Conclusions With Regard to Factual Allegations Arising From the Care and Treatment of Patient C

In Factual Allegation C, Respondent is charged with three separate events constituting the assertion he had an inappropriate and sexual relationship with Patient C during the period of time when he was treating her as a surgical patient. Respondent admits he provided medical treatment to Patient C as described in the Statement of Charges. However, he denies any inappropriate conduct, intimate contact or sexual conduct of any kind.

The allegations arising from the care and treatment of Patient C are somewhat different from the allegations arising from Patient A and Patient B. Patient C was not married at the time of the alleged incidents. In addition, the other-than-medical contact was not as intensely sexual as the contact asserted by the other two patients. On the other hand, to a degree, the nature of the allegations made by Patient C lean toward her credibility, as will be explained below.

The Trier of Fact, has concluded twice in this proceeding that Respondent lied about his relationship with other female Patients. It therefore follows that it is also likely he would lie about his relationship with Patient C. The facts in this case have shown a pattern of efforts by Respondent to engage in other-than-medical relationships with female patients. The combination of Respondent's status as a prevaricator, his apparent propensity to engage in sexual relationships with female patients plus the overall credibility of Patient C leads the Trier of Fact to conclude that Patient C told the truth and that the Factual Allegations which arise from the care and treatment of Patient C are true.

In concluding that Patient C was being truthful and Respondent was not, the Committee takes notice that Patient C harbored significant hostility toward Respondent. She was obviously agitated during much of her testimony and was admonished by the Administrative Law Judge. Nevertheless, the overall logic of her presentation was consistent and her agitation did not seem directed at fabrication so much as frustration. Again, as with Patients A and B, there was not the slightest hint of the use of force by Respondent upon Patient C. Patient C was a willing participant in the encounters.

Again, like Patients A and B, Patient C was subjected to extensive and aggressive cross examination. While some inconsistencies and apparent errors arose in her testimony, they also were deemed minor when compared to the totality of the facts presented. Patient C responded to questions during direct and cross examination in a predominantly decorous and non-hostile manner. She was clearly a dissatisfied and frustrated patient. However, the level of hostility she displayed were at levels that appeared, to the Trier of Fact, to be appropriate to her situation. She appeared genuine in her feelings.

In finding Patient C credible, the Committee notes that her allegations involve flirting, kissing on the mouth and what were other-than-medical massages. The nature of the allegations are important because they do not involve the same level of overt sexuality reported by Patients A and B. If Patient C were solely motivated by anger and a desire to cause harm to a practitioner, one would expect that her allegations would be more dramatic. This, of course, is not to say that kissing a patient on the mouth or making physical contact for an other-than-medical reason is ever acceptable behavior. Nevertheless, it cannot be ignored that were Patient C simply interested in vengeance or financial reward, one would expect her to have made more strident accusations. The fact is that there is little to be gained personally by Patient C in

fabricating her charges. In comparison, as stated previously, Respondent had much to lose by admitting the acts set forth in the charges.

The Committee has found Respondent to be a prevaricator. The Committee finds the assertions of Patient C, in the context of the reports of the other two patients as well as on her own testimony, to be true. Therefore the Committee finds that the Factual Allegations set forth in the Statement of Charges with regard to Patient C are true and must be sustained.

Therefore:

Factual Allegation	**C**	**IS SUSTAINED;**
Factual Allegations	**C (1.) (a) through C (1.) (c)**	**ARE SUSTAINED;**
Factual Allegations	**C (2.) (a) through C (2.) (d)**	**ARE SUSTAINED;**
Factual Allegations	**C (3.) (a) through C (3.)(c)**	**ARE SUSTAINED.**

Findings of Fact Arising From the Care and Treatment of Patient D

1. Patient D was an 88 year old woman who was admitted to St. Clare's on September 20, 1995 with rectal bleeding. Patient D had hypertension. She was obese, and she could not ambulate. (Pet. Ex.11, pp. 12-13; T. 1077-1080 [Respondent]).

2. Respondent saw patient D on September 21, 1995. Respondent's impression was that the patient was bleeding in her gastro-intestinal (GI) system bleed. His initial plan was to transfuse the patient, and to obtain a GI consultation to determine the etiology of the bleeding. (Pet. Ex.11, pp. 12-13; T. 1077-1080 [Respondent]).

3. Respondent's assessment was that the patient was "a poor candidate for emergency surgery," and that "every attempt at conservative management" should be made. (Pet. Ex.11, pp. 12-13; T. 1077-1080 [Respondent]).

4. A gastroenterologist, Dr. Litynski, performed a diagnostic esophageal gastroduodenoscopy (EGD) on Patient D on September 21, 1995. EGD is a procedure where an endoscope is used to look directly into the esophagus, stomach and duodenum. An EGD can be performed to determine the source of a patient's GI bleeding. If a tumor or ulcer is found, it can be biopsied. (Pet. Ex. 11; T. 471-473 [Bulova])

5. An EGD can also be used therapeutically if a patient is continuing to bleed. The bleeding area can be injected with a saline epinephrine mixture or pure saline. A heater probe can also be used to coagulate the bleeding area. (Pet. Ex. 11; T. 471-473 [Bulova]).

6. On September 21, 1995 Dr. Litynski performed an EGD on Patient D. His findings were that she had "a 3 x 4 cm. ulcerated gastric mass at the incisura." Biopsy specimens of the mass were taken. The Dr. Litynski's differential diagnoses included "adenocarcinoma [vs.] lymphoma or less likely benign PUD"(peptic ulcer disease). After looking at the mass, Dr. Litynski believed that it was most likely a malignancy. (Pet. Ex. 11; T. 471-473 [Bulova], T. 1080-1081, 1119 [Respondent])

7. The Dr. Litynski recommended that fluid and blood resuscitation continue, that the patient be transfused to a hematocrit greater than 30, and to "consider a therapeutic EGD if [the patient] re-bleeds." (Pet. Ex.11, pp. 38-39)

8. Respondent was aware of the EGD findings, and spoke to Dr. Litynski the afternoon of September 21 regarding those findings. (Pet. Ex. 11; T. 1080-1082, 1119-1120 [Respondent]).

9. In the early morning hours of September 22, 1995, Patient D began to bleed again. Respondent, took the Patient D to the operating room. (Pet. Ex 11; T. 473-481 [Bulova]; T. 1118-1120 [Respondent]).

10. Taking the patient to the operating room under the circumstances herein was a violation of accepted standards of medicine. (Pet. Ex 11; T. 473-481 [Bulova]; T. 1118-1120 [Respondent]).

11. The surgery was a violation of accepted standards because Dr. Litynski had recommended that a therapeutic EGD should be considered if the patient began to bleed again. Furthermore, The results of the biopsies taken during the diagnostic EGD were not available. (Pet. Ex 11; T. 473-481 [Bulova]; T. 1118-1120 [Respondent]).

12. In September 1995, St. Clare's had a pathologist on call 24 hours a day. The on-call pathologist was available to the surgical service (here, Respondent) to perform services at any hour day or night. (T. 1124 [Respondent]).

13. On September 22, 1995, Respondent could have contacted the on-call pathologist and had him come to the hospital. (T. 1124 [Respondent]).

14. Accepted medical standards require that on occasions when a surgeon suspects he will require the services of a pathologist in surgery, including surgeries which occur during off hours, he requests the on-call pathologist be present. (T. 1377-1378 [Willox]).

15. Accepted standards of medicine required Respondent to summon the pathologist on call for an urgent review of the EGD biopsy slides. (T. 473-487 [Bulova], see T. 1123-1125, 1191-1192 [Respondent]).

16. Respondent did not order any pre-operative antibiotics for the September 22, 1995 surgery he performed on Patient D. (T. 488-490 [Bulova]).

17. Respondent did not order peri-operative antibiotics to be given at the time of the skin incision. (T. 488-490 [Bulova]).

18. Accepted standards of medicine require pre-operative antibiotics for any patient exhibiting the signs and symptoms present in Patient D. The factors requiring pre-operative antibiotics are: surgery of a contaminated viscus and surgery on a patient who has blood in her stomach. (T. 488-490 [Bulova]).

19. Respondent exposed Patient D to the risks of infectious complications, such as intra-abdominal abscess, wound infections, and necrotizing fasciitis by performing such surgery without antibiotic coverage for the patient, (T. 488-490 [Bulova] T. 1381-1382 [Willox]).

20. Accepted standards of medicine make the surgeon responsible for ordering any necessary antibiotics. (T. 491-492 [Bulova]).

21. Respondent's failure to give peri-operative antibiotics to Patient D on September 22, 1995 was a deviation from accepted standards of medical care. (T. 1371-1371, 1381-1382 [Willox]).

22. Respondent testified that when he took Patient D to surgery during the early morning hours of September 22, he planned to perform a gastrectomy regardless of the pathology. (T. 1092, 1099 [Respondent])

23. Respondent failed to summon the on-call pathologist to either read the biopsy slides or do a frozen section. (T. 1091, 1096-1098, 1125-1127 [Respondent]) (Pet. Ex. 11)

24. Respondent did not perform the planned gastrectomy. The reasons cited by him were:

    a. He could not find a mass during the September 22 surgery;

    b. There was a great discrepancy between his findings during surgery
    c. and the gastroenterologist's findings during the EGD;

    d. Respondent did not think the patient had a malignancy based on his own findings;

    e. The patient was unstable and Respondent did not believe she could tolerate a gastrectomy. (T. 1091-1098 [Respondent])

25. Patient D was not unstable during the September 22, 1995 surgery performed by Respondent. (T. 486-488 [Bulova], T. 1399-1403 [Willox])

26. The Patient's blood pressure had caused Respondent concern. (T. 1126-1127 [Respondent])

27. Patient D was not unstable with regard to her blood pressure during the September 22 procedure. (Pet. Ex. 11; T. 1402-1403 [Willox])

28. In a patient such as Patient D, the best surgical treatment for a bleeding ulcer, regardless of pathology, is gastrectomy, if the patient is stable. (T. 1150-1151 [Respondent])

29. Respondent oversewed the malignancy in Patient D. Oversewing a malignancy is a deviation from accepted standards of medical care. Oversewing a bleeding cancer will not stop it from re-bleeding. (T. 481 [Bulova])

30. Given the facts and circumstances presented by D, accepted standards of medicine require the surgeon to perform the best operation he can the first time. This is because a patient like Patient D generally will not present a second opportunity for surgical intervention. (T. 1128-1129, T. 1151 [Respondent])

31. Every operation which is performed or any anesthesia which is induced on someone with significant morbid conditions increases their risk of complications and morbidity. (T. 1385-1386 [Willox])

32. Respondent was "confused" by the discrepancy because he could not find the "3 x 4 centimeter ulcerated mass" described by the gastroenterologist. (T. 1092-1096 [Respondent])

33. Respondent did not document the alleged discrepancy in his operative note or progress note. Respondent did not document that the "discrepancy" was one of the reasons he did not proceed with the gastrectomy he planned. (Pet. Ex. 11, p. 127; T. 1177-1178 [Respondent])

34. Respondent's operative note for the second surgery he performed on Patient D on September 25, 1995, states: "the gastric cancer was palpated in the pre-pyloric area." (Pet. Ex. 11, p. 146; T. 1146 [Respondent])

35. The biopsies taken during the EGD were available on September 25, 1995. The results showed invasive, moderately to poorly differentiated adenocarcinoma. (Pet. Ex. 11, p. 133)

36. The biopsies that Respondent took during the September 22 surgery also showed gastric adenocarcinoma, moderately differentiated and invasive. (Pet. Ex. 11, p. 129)

37. On September 25, 1995, Respondent, performed a second surgical procedure on Patient D. Respondent performed a subtotal gastrectomy with Billroth II reconstruction. Respondent also noted "pus throughout the extent of the abdominal incision," and that "the edges of the fascia appeared necrotic." (Pet. Ex. 11, p.146)

38. Respondent found that there was "pus throughout the extent of the incision." This finding is "a significant description of infection." (T. 1154-1155 [Respondent])

39. In an 88 year old obese patient, such as Patient D, an abdominal wound infection is a serious complication. (T. 1165-1166 [Respondent])

40. Respondent found there was significant infection on this patient. However, Respondent did not order or administer any antibiotics in the operating room on September 25. (Pet. Ex.11)

41. Following the September 25 surgery, Respondent made a post-operative order for Cefotan. Cefotan was an adequate initial choice for a post-operative antibiotic. (T. 499 [Bulova], T. 1375 [Willox])

42. When the results of the wound cultures came back, the cultures revealed that organisms were present that were not sensitive to Cefotan. The anaerobic organisms that were not sensitive were very virulent organisms; specifically, clostridium perfringens and bacteroides. (Pet. Ex.11, p. 187; T. 499-500 [Bulova])

43. Accepted standards of medicine required Respondent, as this patient's surgeon, to affirmatively seek out the culture results, and to change the antibiotics if necessary. Respondent did not meet this mandate. (T. 498-500, 520-523 [Bulova], T. 1384, 1403-1405 [Willox])

44. Based upon the results of the culture tests, Cefotan was an inadequate antibiotic. The antibiotic orders should have been changed after 48 hours. Forty Eight hours is the usual length of time for wound cultures to return. A gram stain or a 24 hour report from the bacteriology lab would provide even faster information. (Pet. Ex. 11, p.187; T. 1404-1405 [Willox])

45. Respondent's operative report for the September 22, 1995 surgery was not dictated until September 27, 1995. A accepted standards of medicine require that a surgeon dictate an operative report within 24 hours of surgery. (T. 503-505 [Bulova], T. 1394-1396 [Willox])

46. Prompt dictation of a surgical report will help to avoid errors in the report that can result from omissions and failure of memory. Other physicians involved in the patient's care should have prompt access to the report so that their care can be consistent with the condition of the patient. (T. 503-505 [Bulova], T. 1394-1396 [Willox])

47. When a surgeon believes there is a discrepancy between his findings and the gastroenterologist's findings on EGD, the surgeon must be particularly careful to make sure that he is not missing a lesion. (T. 1335-1356 [Willox])

48. Respondent's operative report for the September 22 surgery does not mention the discrepancy. (T. 1177-1178 [Respondent])

Conclusions

Arising From
the Care and Treatment
of
Patient D

Under the factual allegations arising from the care and treatment of Patient D, Respondent is charged with two incidents of gross incompetence, two incidents of gross negligence and the lesser included offenses of incompetence on more than one occasion and negligence on more than one occasion. The first incident is a surgery performed on Patient D on September 22, 1995. In the performance of that surgery, Respondent is charged with:

a.) Performing the wrong surgery for the situation;

b.) Failing to order or administer antibiotics prior to and during the surgery[4].;

c.) Failing to obtain a frozen section; and

d.) Failing to compose a timely or adequate operative report for this surgery.

Many of the facts associated with Patient D are undisputed. Patient D was an 88-year-old frail woman in poor health. Dr. St. Lucia performed surgery on Patient D on September 22, 1995 and September 25, 1995. Dr. St. Lucia performed the September 22, 1995 procedure because Patient D was bleeding internally. At the time of the surgery, Patient D had been examined by Dr. Litynski, a gastroenterologist, who performed a diagnostic esophageal gastroduodenoscopy EGD. The differential diagnoses for this patient based upon the EGD findings included "adenocarcinoma [vs.] lymphoma or less likely benign PUD(peptic ulcer disease)". The mass which was discovered by the gastroenterologist was considered to be probably malignant. The treatment plan was that fluid and blood resuscitation would continue; The patient would be transfused to a hematocrit greater than 30; and a therapeutic EGD would be performed if the

[4]The State withdrew part of this charge having to do with post operative antibiotics.

patient were to resume internal bleeding. Given the aged and frail nature of this patient, accepted standards of medical care mandated the most conservative and least invasive therapy available.

Respondent was aware of the EGD findings, and spoke to Dr. Litynski the afternoon of September 21 regarding those findings and the treatment plan. In the early morning hours of September 22, 1995, Patient D began to bleed again. Respondent had the patient taken to the operating room. He performed surgery in which he oversewed what he believed to be an ulcer. While a pathologist was on call at the time and could have been summoned to the hospital on short notice, Respondent did not take advantage of the availability. Respondent explained that he intended to perform a gastrectomy regardless of the pathology he found. Therefore, he believed he did not need the services of a pathologist. However, according to Respondent, when he was able to visualize the actual internal condition of the patient, he did not see the conditions described by the gastroenterologist. Furthermore, as the surgery progressed, Respondent states the patient became unstable. Therefore, he abandoned his intention to perform the gastrectomy and oversewed what he believed to be a bleeding ulcer.

It is the conclusion of the Trier of Fact that Respondent should have performed a gastrectomy on Patient D. Respondent had no adequate excuse for not doing so. Respondent admitted, in a patient such as Patient D, the best surgical treatment for a bleeding ulcer, regardless of pathology, is gastrectomy, if the patient is stable. Respondent stated that Patient D was unstable. However, the patient record shows this was not the case. Furthermore, oversewing a bleeding cancer will not stop it from re-bleeding. Since the primary goal of the surgery was to end the bleeding in this patient, Respondent's choice was not in the best interest of his patient.

Respondent's claim that he could not find the conditions described by the gastroenterologist and therefore, concluded the problem to have been caused by an ulcer is

unacceptable. While a diagnostic error can often be excused, under the circumstances, Respondent's error could and should easily have been avoided. Accepted standards of care dictated that under the circumstances, the on call pathologist be summoned. The basis for the standard is played out in the facts of this surgery: Respondent was aware of the findings by the gastroenterologist. When his findings were significantly different from those of the gastroenterologist, he had a higher duty to seek the assistance of an expert to confirm or correct his diagnoses during the surgery. Respondent claims that time was of the essence, yet the patient was stable. Furthermore, had he made the appropriate arrangements for the pathologist to be present, little delay would have occurred.

The failure of Respondent to continue the treatment plan developed with the assistance of an expert in the field cannot be explained away by exigent circumstances or a lack of available resources. Respondent's acceptance of a significantly divergent diagnosis without confirmation by available consultants also cannot be excused by the condition of the patient or the hour of the surgery. The acts proven constitute a serious deviation from accepted standards of care and diligence and demonstrates a significant failure of basic knowledge and expertise.

With regard to the administration of antibiotics, Respondent has admitted that he failed to order antibiotics for this patient prior to or during the surgery. While Respondent would have the Trier of Fact consider this lapse to be of little moment, it is actually a very serious deviation from accepted standards. It is well known by physicians in general and surgeons in particular, that in surgery such as that undertaken with Patient D, infection is a very common and potentially life threatening consequence. Hence, the ordering of antibiotics in this situation would have been reflexive for a physician exhibiting basic standards of care and diligence as well as fundamental expertise.

Finally, Respondent admits he failed to file an operative report within the appropriate time frame. When he did write his report, Respondent did not make any mention of the significant discrepancy between his findings and those of the expert. While the treating clinician may well make findings that are significantly different from those of a diagnostic expert, basic standards of medicine require that those significant discrepancies be carefully and completely recorded. In this case, but for the explanation of Respondent, subsequent treating personnel and reviewers would have no way to know why the treatment rendered was so different from that originally proposed.

Present day medicine makes the production of adequate and timely reports an integral part of patient care. In this case, Respondent's testimony is not consistent with his report. In other instances, information which should have been included in the report is not included. Such lapses are important and directly address the level of care and diligence as well as the standard of competence exhibited by a physician. Prudent, competent physicians produce accurate, complete and timely patient records.

In the second incident, a surgery performed on Patient D on September 25, 1995, Respondent is charged with:[5]

a.) Failing to order or administer adequate antibiotic therapy after the surgery; and

b.) Failing to compose a timely or adequate operative report for this surgery.

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[5] The Board withdrew a charge relating to the debridement performed by Respondent in this surgery.

With regard to the use of antibiotics, while the initial choice of Cefotan is not in dispute. Respondent was also required to see that cultures were performed so that the precise nature of the infection could be known and the correct anti-biotic prescribed. The process of culturing bacteria typically takes twenty four hours. In this case, the purpose of the culture was shown by the results: The original choice of antibiotic was ineffective against the organisms actually present. Hence, after the cultures had been received Respondent, was under a duty to change the antibiotic. He did not do so.

This process of using a broad spectrum antibiotic until the true nature of the infection can be discovered followed by an adjustment of the antibiotic to address the precise organisms present, is a basic and fundamental process in the every day practice of medicine. The failure by Respondent to follow up on this patient is an extreme deviation from basic accepted standards of medicine.

Once again, Respondent failed to file an operative report in a timely manner. His testimony was necessary to explain exactly what had happened to this patient. The whole purpose of providing a timely, accurate and adequate operative report is to allow necessary parties to be fully informed in the absence of the practitioner. Respondent did not meet this standard.

Therefore:

Factual Allegation	**D**	**IS SUSTAINED;**
Factual Allegation	**D (1.)**	**IS SUSTAINED;**
Factual Allegation	**D (1.) (a)**	**IS SUSTAINED;**
Factual Allegation	**D (1.) (b)**	**WAS WITHDRAWN;**
Factual Allegations	**D (1.) (c) and D (1.) (d)**	**ARE SUSTAINED;**
Factual Allegation	**D (2.)**	**IS SUSTAINED**
Factual Allegations	**D (2.) (a)**	**WAS WITHDRAWN;**
Factual Allegations	**D (2.) (b) and D (2.) (c)**	**ARE SUSTAINED;**

Findings of Fact
Arising From
the Care and Treatment
of
Patient E

1. Patient E, a 33 year old male who was HIV positive. He was referred to Respondent by his primary care physician, Dr. Doucet, for placement of a Porta-Cath for long-term antibiotic therapy for CMV retinitis. (Pet. Ex. 12; T. 694-697 [Respondent])

2. Respondent did not see or examine Patient E in his office prior to surgery. (Pet. Ex. 12; T. 753-755 [Respondent])

3. This was not an emergency procedure, and there was no reason that the surgery had to be performed immediately. Time was available for Respondent to have arranged to see Patient E in his office prior to surgery. (T. 528 [Bulova], T. 1339 [Willox], T. 733-734 [Respondent])

4. Accepted standards of practice require that a surgeon see a patient in the office prior to surgery in order to be able to spend more time with the patient and take a good history and physical examination. (T. 754-755 [Respondent] T. 1328, 1343 [Willox])

5. Patient E was admitted to St. Clare's on October 3, 1995 for placement of the Porta-Cath by Respondent. (Pet. Ex. 12)

6. Respondent performed a pre-operative history and physical examination of Patient E in St. Clare's, the morning of the surgery. The examination and history lacked important elements that were relevant for a patient such as Patient E undergoing this procedure. Some of the missing elements include:

   A. Vital signs;

   B. Temperature;

   C. Any history with regard to whether the patient had signs of bleeding;

   D. Any history of easy bruising, bleeding from brushing his teeth, and whether he was using aspirin or other medications that would inhibit platelet functioning; (T. 553 [Bulova], T. 1334-1335 [Willox]

7. The only pre-operative testing that Respondent ordered for Patient E was a CBC and differential. Respondent did not order any bleeding times or clotting times for this patient. (Pet. Ex. 12; T. 1353-1355 [Willox])

8. In a patient such as Patient E, pre-operative coagulation studies are required to ascertain whether Patient E had normal clotting hemodynamics. (T. 528-529 [Bulova])

9. Respondent did not consult with a hematologist regarding Patient E. (T. 1347-1348 [Willox])

10. Respondent did not order liver function studies. (Pet. Ex. 12, 21; T. 1328 [Willox])

11. The temperature of Patient E would be a particularly important vital sign to note for Patient E because patients who are HIV positive may well be immuno-compromised and unable to fight infection (T. 546, 553 [Bulova])

12. If there was evidence of an ongoing infection, it would need to be cleared up before the port could be inserted. If it is not cleared up prior to placement, the patient would be placed at high risk of having an infected port. (T. 528-529, 553 [Bulova])

13. It would be important to know if the patient's platelets were functioning properly. (T. 1331, 1333 [Willox])

14. Patients with HIV, because of their disease process, often have depressed blood counts which may need to be corrected pre-operatively. (T. 529 [Bulova], see also T. 729 [Respondent]

15. Patient E was noted to be taking Neupogen at the time of the surgery. Neupogen is a white blood cell simulator for patients who are neutropenic. The patient was also receiving Epogen. Epogen is used to boost the patient's red blood cell count. (Pet. Ex. 12; T. 553 [Bulova], T. 728-729 [Respondent])

16. The pre-operative blood tests performed on Patient E showed he had a platelet count of 44,000. (Pet. Ex. 21, Pet. Ex. 12; T. 530 [Bulova])

17. Patient E was suffering from thrombocytopenia. Thrombocytopenia is a condition in which the patient has a lowered platelet count. (T. 530 [Bulova], T. 1329 [Willox]

18. Respondent was not aware that Patient E suffered from thrombocytopenia pre-operatively. (Pet. Ex. 12; T. 1339-1341, 1358 [Willox], T. 553-554 [Bulova], T. 732-733, 769-771 [Respondent])

19. On October 3, 1995, Respondent performed surgery on Patient E. (Pet. Ex. 12)

20. There are a number of surgical approaches which a surgeon can use for placement of a Porta-Cath. Respondent chose a blind percutaneous subclavian approach. (Pet. Ex. 12; T. 703-704)

21. Respondent perforated the subclavian artery, causing the patient to bleed. (T. 736 [Respondent])

22. When employing a blind percutaneous procedure, the physician cannot visualize bleeding. In addition, he may not realize that the patient is bleeding at all. These are some of the recognized risks that arise from the use of the blind procedure. (Pet. Ex. 12, p. 20; T. 736-743 [Respondent])

23. At the conclusion of the procedure, Respondent did not know that Patient E was bleeding. The patient was sent to the Recovery Room. (Pet. Ex. 12, p. 20; T. 736-743 [Respondent])

24. While Patient E was in the Recovery Room, his condition deteriorated. He became hypotensive, and his blood pressure dropped to 54/38. (Pet. Ex. 12, p. 20; T. 736-743 [Respondent])

25. Respondent was called in and inserted a chest tube, which was attached to an Emerson pump. On the initial insertion, approximately 800 cc. of blood was evacuated. A CBC revealed a platelet count of 28,000, hemoglobin of 5.5 and hematocrit of 15.8.(Pet. Ex. 12; T. 741-744 [Respondent])

26. Patient E was transfused with multiple units, including at least twelve units of platelets. (Pet. Ex. 12; T. 741-744 [Respondent])

27. A chest x-ray revealed a large amount of clotting in the patient's right chest. (Pet. Ex. 12; T. 744-745 [Respondent])

28. A thoracic surgeon, Dr. Condon, was called in and performed a thoracotomy on Patient E. A thoracotomy is a surgical opening of the chest to explore the chest cavity. (T. 745 [Respondent])

29. A thoracotomy was performed to determine if Patient E continued to have active bleeding, as well as to evacuate all the blood and clots from his chest (Pet. Ex. 12; T. 542-543 [Bulova])

30. For a patient in Patient E's condition, the necessity of performing a thoracotomy on him to address his bleeding exposed him to great risks, including infection, poor wound healing and further bleeding. (T. 542-543 [Bulova])

31. A thoracotomy is a major operative procedure during which Patient E was subjected to general anesthesia and a large chest incision. Patient E did not need to have general anesthesia for the Porta-Cath insertion. (T. 543 [Bulova], T. 745-746 [Respondent])

32. Respondent did not dictate his Operative Report for the October 3, 1995 procedure he performed on Patient E until October 16, 1995, thirteen days after the procedure. (T. 504-505 [Bulova], T. 747 [Respondent]

33. Operative reports should be done within 24 hours of surgery. Patient E suffered serious post-operative complications. This fact made it even more important for Respondent to have dictated the report in a timely manner. (T. 1345-1346 [Willox])

34. Respondent's Discharge Summary was dictated after Patient E had already experienced serious post-operative complications, and had been hospitalized for seven days when the placement of the Port-Cath was to have been an outpatient surgical procedure. (Pet. Ex. 12; T. 543-545 [Bulova])

35. Respondent's discharge summary nevertheless states that the Porta-Cath insertion procedure went well. This is not an accurate characterization, particularly in light of the

patient's subsequent course, which was known to Respondent at the time he dictated his discharge summary. (T. 546-547 [Bulova])

Conclusions Arising From the Care and Treatment of Patient E

Patient E, a 33 year old male who was HIV positive, was referred to Respondent by his primary care physician, Dr. Doucet, for placement of a Porta-Cath for long-term antibiotic therapy for CMV retinitis. The placement of the Porta-Cath was an elective procedure. Nevertheless, Respondent did not see or examine Patient E prior to surgery. Respondent acknowledged that he could have arranged to see Patient E prior to surgery. Respondent also acknowledge that it is good medical practice to see a patient in the office prior to surgery in order to be able to spend an appropriate amount to time with the patient and prepare a high quality history and physical examination. Accepted standards of medicine, as stated by Respondent's own expert, Dr. Willox, require that a patient such as Patient E be seen Patient E pre-operatively unless time is of the essence. The parties agree this was not an emergency procedure, and there was no reason that the surgery had to be performed immediately. Hence, there was no reason not to see Patient E prior to surgery.

Respondent performed a pre-operative history and physical examination of Patient E, at St. Clare's Hospital on the morning of the surgery. The history and physical examination did not meet accepted standards of medicine because they lacked important relevant elements for a patient such as Patient E undergoing this procedure. The history and physical taken did not

record the vital signs of the patient, including temperature. Aside from the obvious basic nature of the necessity to measure and record the temperature of a patient about to undergo surgery, the failure to record this particular patient's temperature had special significance. The temperature of an HIV positive patient could alert the practitioner to an infection or disease process. Patients who are HIV positive may well be immuno-compromised and unable to fight infection. Such a patient may have an ongoing infection which would need to be cleared up before the port could be inserted, or the patient would be placed at high risk of having an infected port.

In addition to ignoring the vital signs of this patient, many pertinent negatives were omitted from the patient's history, particularly any history with regard to whether the patient had signs of bleeding. Respondent should have asked and documented whether Patient E had easy bruising, bleeding from brushing his teeth, and whether he was using aspirin or other medications that would inhibit platelet functioning. Such information could alert a practitioner to clotting problems in the patient. Examination of the ability of the patients blood to clot would be important to have for a patient such as Patient E in considering whether it was safe to perform this procedure. It would be important to know if the patient's platelets were functioning properly. Respondent did not order any bleeding times or clotting times for this patient. Pre-operative coagulation studies should have been ordered to ascertain whether Patient E had normal clotting hemodynamics. The necessity of blood studies is underscored by the fact Patient E was noted to be taking Neupogen, which is a white blood cell stimulator for patients who are neutropenic, as well as Epogen, which is to boost the patient's red blood cell count.

In addition to failing to order important blood tests, Respondent did not order liver function studies. Liver studies are again a standard pre-operative study. Given the nature of Patient E's malady such a study is of even greater importance.

Not only did Respondent fail to perform basic and important tests, he did not properly respond to the results he did obtain. Patients with HIV, because of their disease process, often have depressed blood counts which may need to be corrected pre-operatively. Indeed, in this case, the pre-operative blood tests performed on Patient E showed he had a platelet count of 44,000. This platelet count was far below the normal range.

There is nothing in Patient E's medical record to indicate that Respondent was aware of Patient E's platelet count pre-operatively. Respondent did not document that he was aware of the condition of the patient. Perhaps of greater importance, Respondent did not document why he did not take any measure to address the patient's ability to clot. Respondent had a duty to either consult a hematologist, order additional studies, or possibly transfuse the patient with platelets pre-operatively. In the alternative, he had a duty to note why he had not done so.

While the Committee take no issue with the performance of the blind percutaneous placement of the subclavian line. The fact is that both experts agreed that the approach did not violate accepted standards of medicine. With regard to the platelet count, while clearly low, the performance of surgery at 44,000 platelets is a judgment which is within accepted standards of medicine. There were no extenuating circumstances which would have made the procedure, under the conditions noted, to be a violation of accepted standards.

With regard to the timeliness of the operative report, Respondent was again significantly late with this operative reports. The fact that Patient E suffered serious post-operative complications highlights the reason for dictation in a timely manner. The fact is that later practitioners did not have the benefit of the surgical report to assist them in diagnosing and treating Patient E. Furthermore, Respondent did not include his rationale for the treatment provided. This is an integral part of a patient record that meets accepted standards of medicine.

Perhaps more troubling than the tardiness of his reports is his failure to accurately report very significant events. In the case of the Discharge Summary for this patient, Respondent's dictated it after Patient E had already experienced serious post-operative complications. Patient E had been hospitalized for seven days although the placement of the Port-Cath was to have been an outpatient surgical procedure. Nevertheless, Respondent's discharge summary states that the Porta-Cath insertion procedure went well. This is far from an accurate description of the course of this patient, which was known to Respondent at the time he dictated his discharge summary.

Therefore:

Factual Allegation	**E.**	**IS SUSTAINED;**
Factual Allegation	**E (1.)**	**IS NOT SUSTAINED;**
Factual Allegation	**E (2.)**	**WAS WITHDRAWN;**
Factual Allegations	**E (3.) and E (4.) (c)**	**ARE SUSTAINED;**

CONCLUSIONS
WITH REGARD TO
THE FIRST SECOND AND THIRD
SPECIFICATIONS
(Moral unfitness)

Having sustained the Factual Allegations arising from the care and treatment of Patients A, B and C, the Committee now turns its attention to the specifications to decide if the conduct proven constitutes medical misconduct as defined in the relevant statutes. In the First through Third Specifications, Respondent is charged with committing conduct in the practice of medicine

which evidences moral unfitness to practice medicine in this state. As set forth in the instructions to the Trier of Fact, there are two questions to be answered in assessing whether or not the specifications can be sustained: First, did Respondent violate the trust bestowed upon a physician solely by virtue of his licensure as a physician in this state; Second, did Respondent violate the moral standards of the medical community of this state?

At the outset, it is noteworthy that even if Respondent had admitted he and the three patients had engaged in sexual relationships, there is no legal provision which makes a sexual relationship between a physician and a patient, medical misconduct *per se*[6]. Reasonable minds might argue about the quality of a practitioner's judgement where there is a sexual relationship between a patient and a physician, but debatable judgement alone does not constitute medical misconduct. Therefore, the issue in this part of the proceeding is not merely whether two consenting adults, one a patient and the other a practitioner, had a sexual relationship. Rather, the question is whether Respondent, by engaging in the conduct proven, violated the trust that was bestowed upon him solely because he is licensed to practice medicine in this state.

The facts established by Patient A are a perfect example of numerous violations of the trust referred to herein. But for the fact that Respondent was her physician, Respondent would not have known that Patient A was feeling deeply vulnerable and questioning her adequacy as a woman at the time of the incidents. Respondent knew Patient A was concerned that her husband might no longer find her attractive. Therefore, Respondent knew she was much more likely to accept the overtures of a man other than her husband. For the assignations to have occurred, Patient A had to submit to the overtures extended by Respondent. Nevertheless, the fact is that Respondent had an ethical advantage over any other male that Patient A might have been in

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[6] Pursuant to Section 6530(44) sexual contact between a patient and a physician "in the practice of psychiatry" constitutes professional misconduct *per se*. This provision does not apply to this matter.

contact with at that time. That advantage resulted solely from the trust bestowed upon Respondent by virtue of his licensure.

While it is true that Patient A was free to reject the overtures made by Respondent, the relationship which developed between Respondent and Patient A was not entirely one of two consenting adults of equal stature and judgment. Given the mental and physical condition of Patient A so close to the surgery, she was at a distinct disadvantage in her ability to think and reason appropriately. Hence it was completely and utterly inappropriate for Respondent to have made such overtures to Patient A at the time. Respondent knew, better than anyone, that Patient A was in no condition to make major life effecting decisions; like whether to have an affair and take a chance on ruining her marriage. Instead of respecting the condition of his patient, Respondent nefariously used her condition to his own salacious advantage. There are those who would argue that it is never appropriate for one to take advantage of another's weaknesses in order to be successful in a seduction. Certainly, there is no one who can rightly argue that it is ever appropriate for a physician to take advantage of weaknesses in a patient in order to be successful in a seduction. The choice of Respondent to do so is therefore unconscionable.

In addition to familiarity with the emotional stress of Patient A, Respondent had other advantages arising from his position as physician. Respondent, solely because he was Patient A's treating physician, was able to meet her in private places for private conversations at St. Claire's. He repeatedly offered her the promise of comfort which arises from medical care. He encouraged her to think of him as a source of respite from a very difficult and painful (both mentally and physically) time in her life. As her trusted physician, Respondent held a position of authority over Patient A. In her testimony, Patient A stated that she was gratified by Respondent's attention, not so much simply because he was a male, but rather, because he held special authority in her life as her physician. Respondent's acts perverted that authority over

Patient A. Rather than using his elevated standing to comfort and protect his patient, he used that authority as a tool to obtain personal gratification from Patient A.

In addition to the various violations of trust which arise from Respondent's seduction of Patient A, there are a number of practical standards of trust which Respondent violated in his contact with Patient A. First, Respondent encouraged Patient A to have unprotected sex with him. Of even greater concern was his assurance to Patient A that the physical engagement in intercourse, so close to the time of the surgery, was within acceptable medical standards. It is not the province of this body to comment upon mendacity between sex partners. However, when a physician lies to a patient over a clearly medical issue, such as birth control, transmissible diseases and the possible complications of surgery, that is the province of medical misconduct. The fact is that by his own admission, at the time of the assignation, Patient A had not had sufficient time to heal such that Respondent would not have approved of conjugal relations between Patient A and her husband. Notwithstanding the assurance of Respondent that "he did not have sex with just anyone," it is unconscionable that he would use his authority as a physician to overcome Patient A's concerns about unprotected sex.

Patients, their families and spouses have a right to be able to rely upon physicians not to take advantage of them or their loved ones. The facts established by Patient A demonstrate a violation of the responsibility Respondent had to her as a patient. He also violated the trust of Patient A's husband and that of her family as a whole. Respondent placed his own gratification above the trust bestowed upon him solely by virtue of his licensure. In so doing he egregiously violated the first sub-definition of conduct evidencing moral unfitness.

Turning now to the second sub-definition of conduct evidencing moral unfitness to practice medicine, the Committee finds an extraordinary level of repeated violations of some of the most basic moral tenets of the medical community. The medical community of this state expects

physicians to be trustworthy in all patient dealings. As cited above, Respondent herein took unconscionable advantage of Patient A based upon information he had been given solely because he was her physician. Furthermore, he used his inherent authority against the inhibitions of Patient A. In so doing he betrayed the patient, her family and the entire medical community.

In addition to the betrayal of trust demonstrated by Respondent, Respondent made virtually no distinction between his meetings with Patient A as a physician and his meetings with her as a seducer. Perhaps the most significant example of this behavior occurred during the liaison at the motel. During the sex act, there came a point where Respondent complained to Patient A that he felt something sharp inside of her. In a moment, Respondent changed roles and positions from that of a sex partner to a physician providing a pelvic examination. He diagnosed the problem as resulting from suture material in Patient A's vagina. He then resumed intercourse. After intercourse, as the parties were preparing to leave, Respondent advised Patient A to have a mole on the inside of her thigh examined. Some time after the event, he telephoned Patient A to advise her to use a feminine hygiene product in order to remove the foreign matter.

This apparently seamless transference between licensed practitioner and illicit sex partner and back again is both an unacceptable and an unforgivable derogation of the morality of the medical community. It also demonstrates the way Respondent perverted his authority as a physician: He demonstrated to Patient A that he not only had power over her as a sex partner but continued to have power over her as a physician. The acts and attitudes shown by Respondent demonstrate a dangerous void in Respondent's understanding of acceptable conduct within the practice of medicine.

Turning to Patient B, while some of the conclusions stated above are parallel to the conclusions associated with Patient B, there are also some significant differences. Unlike Patient A, Patient B had not undergone recent surgery of a life changing nature. However, Patient B and her husband were having marital problems at the time. She was in a vulnerable state. Respondent knew that Patient B's marriage was in a vulnerable state. By using this knowledge to seduce Patient B, Respondent violated the trust bestowed upon him solely by virtue of his licensure.

In addition to using personal information obtained solely as a medical practitioner, for his own gratification, Respondent further betrayed the trust bestowed upon him by using visits to his medical office to put forward ambiguously suggestive comments to see if Patient B would respond. When Patient B did answer favorably, Respondent perverted his privilege of weekend access to St. Claire's hospital. This privilege was given to him to facilitate patient treatment. Instead, on weekends, he used his office at St. Claire's Hospital as a convenient and cost free rendezvous site for his assignations with Patient B.

As was the case with Patient A, Respondent used the prestige and authority of his licensure to aid him in the seduction of Patient B. It was only because he was her doctor, that Respondent had any authority to call her at home. While there is no empiric way to measure it, the fact that he met Patient B at the hospital, which was his professional territory, enhanced his authority over Patient B. Furthermore, given the unstable nature of her marriage at the time, and the fact that Respondent was a high status member of the community, the attention and compliments he gave to Patient B were particularly flattering to her.

Patients, their families and spouses, indeed the community as a whole, have a right to rely upon physicians not to take advantage of their patients. The facts established by Patient B demonstrate a violation of the responsibility Respondent had to her as a patient. He also violated

the trust of Patient B's husband, that of her family and that of the community as a whole. Respondent placed his own gratification above the trust bestowed upon him solely by virtue of his licensure. In so doing he egregiously violated the first sub-definition of conduct evidencing moral unfitness.

Turning now to the second sub-definition of conduct evidencing moral unfitness to practice medicine, the Committee finds an extraordinary level of repeated violations of some of the most basic moral tenets of the medical community. The medical community of this state expects physicians to be trustworthy in all patient dealings and to appropriately separate their personal needs and desires from their professional responsibilities. As cited above, Respondent herein took unconscionable advantage of Patient B based upon information he had been given solely because he was her physician. Furthermore, he used his inherent authority over Patient B to overcome her inhibitions. He called Patient B when her husband was home. In so doing he participated in duping a man to whom he owed professional trust. The spouses of patients have a right to believe that when their partner seeks medical care, it is not going to lead to adultery. By engaging in the cabal against Patient B's husband, Respondent placed his personal desire to seduce Patient B over his professional responsibility to perform in a trustworthy manner.

In addition to the betrayal of trust demonstrated by Respondent was the confusion of the distinction between Respondent as licensed physician and Respondent as a wanton seducer. As with Patient A, in his relationship with Patient B Respondent made virtually no distinction between his meetings with Patient B as a physician and his meetings with her as a seducer. The fact that Respondent included his "on call" status as a part of his plan to rendezvous with Patient B plus the fact that he used his medical office as the site of the rendezvous is a violation of accepted moral standards of the physicians of this state.

As set forth previously, Respondent's apparent ability to transfer personae between licensed practitioner and illicit seducer and back again is both an unacceptable and an unforgivable derogation of the morality of the medical community. The acts and attitudes shown by Respondent demonstrates a dangerous void in Respondent's understanding of acceptable conduct within the practice of medicine.

The Committee now turns its attention to Patient C. Patient C was deeply concerned, some might say eventually she became obsessed, over the possibility she would develop breast cancer. As with the two previous patients, Respondent used this fear-based obsession to obtain the trust of Patient C. As with the two previous patients, Respondent learned information that would not have been available to him but for his status as a physician. Respondent used his medical license to find a vulnerability in Patient C and used this vulnerability for his own nefarious purposes. He offered to make medical arrangements and obtain cancer related information for Patient C beyond that which might be considered ordinary medical care. Ostensibly, his motive was to assist Patient C with her treatment concerns. However, the full facts show his motive was ingratiate himself with Patient C, make her dependant upon him and hence create an opportunity for seduction and sexual activity.

In addition to using personal information obtained solely as a medical practitioner, Respondent further betrayed the trust bestowed upon him by using visits to his medical office to assess whether Patient C might be willing to engage in an other-than-medical relationship with him. The incident involving the bet that Patient C would not be able to stop smoking could, at first blush, be dismissed as a health-related incentive or mere flirtation of questionable judgement. However in the context of offering to meet Patient C at his office at off hours, it becomes clear that Respondent was seeking a relationship with Patient C. As with Patient A and Patient B,

Respondent perverted the privilege of having access to a patient in the privacy of his examination rooms at St. Claire's. As with Patient A and Patient B, Respondent also perverted the privilege of having access to St. Claire's on weekends by using his office as a convenient and cost free rendezvous site for clandestine meetings with Patient C.

As was the case with Patient A and Patient B, Respondent used the prestige and authority of his licensure to aid him in obtaining private time with Patient C. It was only because he was her doctor, that Respondent had any authority to call her at home. It was only because he was her doctor, that Respondent had any authority to invite her to his office after hours. While there is no empiric way to measure it, the fact that he met Patient C at the hospital, which was his professional home territory, enhanced his authority over Patient C as a potential sex partner. Like Patient A and Patient B, Patient C found Respondent's attention and compliments particularly flattering because of his stature as a physician.

Patients, their families and spouses, indeed the entire community, have a right to be able to rely upon physicians not to take advantage of their patients. Notwithstanding that Respondent and Patient C never engaged in coitus, he kissed her on the mouth and made several highly suggestive remarks to her. Respondent placed his own gratification above the trust bestowed upon him solely by virtue of his licensure. In so doing he egregiously violated the first sub-definition of conduct evidencing moral unfitness.

Turning now to the second sub-definition of conduct evidencing moral unfitness to practice medicine, the Committee finds an extraordinary level of repeated violations of some of the most basic moral tenets of the medical community. The medical community of this state expects physicians to be trustworthy in all patient dealings and to appropriately separate their personal needs and desires from their professional responsibilities. As cited above, Respondent herein took

unconscionable advantage of Patient C based upon information he had been given solely because he was her physician.

As discussed in the context of Patient A and Patient B, in addition to the betrayal of trust demonstrated by Respondent was the confusion of the distinction between Respondent as licensed physician and Respondent as a participant in illicit sex. As with Patient A and Patient B, in his relationship with Patient C, Respondent made virtually no distinction between his meetings with Patient C as a physician and his meetings with her as a seducer. The fact that Respondent included his "on call" status as a part of his plan to rendezvous with Patient C plus the fact that he used his medical office as the site of the rendezvous is a violation of accepted moral standards of the physicians of this state.

As set forth previously, Respondent's apparent ability to transfer personae between licensed practitioner and illicit sex partner and back again is both an unacceptable and an unforgivable derogation of the morality of the medical community. The acts and attitudes shown by Respondent demonstrates a dangerous void in Respondent's understanding of acceptable conduct within the practice of medicine.

Therefore:
The First Specification is SUSTAINED;
The Second Specification is SUSTAINED;
The Third Specification is SUSTAINED;[7]

[7]The Committee wishes to affirm that should any individual Factual Allegation (now finding of fact) later be overturned or modified, the Committee would still find that based upon each of the remaining allegations Respondent demonstrated conduct evidencing moral unfitness in the practice of medicine. Respondent committed acts evidencing moral unfitness both in the totality of the various accounts and in each act proven.

CONCLUSIONS WITH REGARD TO THE FOURTH AND FIFTH SPECIFICATIONS
(Gross Negligence)

Having sustained the majority of Factual Allegations arising from the care and treatment of Patients D and E, the Committee now turns their attention to whether the acts proven constitute gross negligence and the lesser included offense of ordinary negligence. As set forth earlier, to establish gross negligence, the Board must show Respondent either egregiously deviated from accepted standards of care and diligence on one occasion or deviated in a non-egregious manner from accepted standards on more than one occasion, such that the activity in the aggregate constitutes an egregious deviation from standards.

In the care and treatment of Patient D, the Committee finds both standards were met. Patient D had been examined and diagnosed by an expert in the relevant field. A care plan had been established. Nevertheless, Respondent chose to deviate from the care plan without any confirmatory consultation. The Committee takes particular note that when Respondent performed surgery and found a situation very different from that described by the expert consultant, he made no effort to affirm his observations. Rather, he took action, which turned out to be inappropriate under the circumstances. Additional surgery and additional risk to the patient resulted. Hence, the deviation from the extant care plan in the absence of an appropriate explanation in the patient record, is an egregious deviation from accepted standards of care and diligence.

It is undisputed that Respondent failed to treat Patient D with appropriate antibiotics before and during the first surgery. The failure of Respondent to provide appropriate antibiotic therapy is a violation of so basic a medical tenet that it warrants the term gross negligence. The fact is

that physicians acting within the most basic tenets of care and treatment would have provided Patient D with antibiotic care.

Respondent made no effort to obtain the assistance of the on call pathologist. Had he done so the pathologist could have assisted Respondent in sorting out the obvious discrepancy between his observations during surgery, and those of the gastroenterologist. Performing the surgery in the absence of an available pathologist constituted a most serious deviation from accepted standards. In so doing, Respondent decided to begin the procedure without taking a basic and fundamental precaution, essential to patient care.

The failure of Respondent to change his choice of antibiotic upon receipt of the culture report is also an act of gross negligence. The purpose of taking a culture is to make sure that the patient is receiving the best antibiotic for the infectious process. The culture report in this instance makes it clear that the initial choice was incorrect for the extant infection. Again, this failure to act is an egregious departure from accepted standards of care and diligence and hence, constitutes gross negligence

Finally, Respondent admits he failed to file an operative report within the appropriate time frame. When he did write his report, Respondent did not make any mention of the significant discrepancy between his findings and those of the expert. While the treating clinician may well make findings that are significantly different from those of a diagnostic expert, basic standards of medicine require that those significant discrepancies be carefully and completely recorded. In this case, but for the explanation of Respondent, subsequent treating personnel and reviewers would have no way to know why the treatment rendered was so different from that originally proposed.

Present day medicine makes the production of adequate and timely reports an integral part of patient care. In this case, Respondent's testimony is not consistent with his report. In

other instances, information which should have been included in the report is not included. Such lapses are important and directly address the level of care and diligence as well as the standard of competence exhibited by a physician. Prudent, competent physicians produce accurate, complete and timely patient records.

In the assessment of this case, the Committee finds six occasions when Respondent acted in a grossly negligent manner:

1. The failure to adhere to the care plan in the absence of a clear basis for same;

2. The failure to arrange for the presence of the on call pathologist prior to surgery;

3. The failure to consult with the on call pathologist when Respondent's observations were extremely different from those of the gastroenterologist.

4. The failure to provide appropriate antibiotic therapy before and during the first surgery.

5. The failure to provide appropriate antibiotic therapy after the cultures were received for the second surgery.

6. The failure to provide a timely and accurate operative report.

At each of these events, Respondent could have made the correct decision and moved within accepted standards of care and diligence. However, he did not. Instead he committed yet another act which was an egregious deviation from standards. Therefore it can be said that Respondent committed at least six distinct acts which, separately and together, constitute an egregious deviation from standards of care and diligence.

The attitude demonstrated in the failure to meet the care standards in Patient D is dangerous in any physician and shows a desire to end the case rather than make a careful

diagnosis. The lack of care and diligence is an extreme deviation from accepted standards and therefore constitutes gross negligence.

Turning now to Patient E, the Committee does not find any acts of gross negligence. The two Factual Allegations which were sustained, while not acceptable conduct, do not rise to the level of gross negligence.

Therefore:
The Fourth Specification is **SUSTAINED;**
The Fifth Specification is NOT SUSTAINED;

CONCLUSIONS
WITH REGARD TO
THE SIXTH AND SEVENTH
SPECIFICATIONS
(Gross Incompetence)

Having sustained the majority of Factual Allegations arising from the care and treatment of Patients D and E, the Committee now turns their attention to whether the acts proven constitute gross incompetence and the lesser included offense of ordinary incompetence. As set forth earlier, to establish gross incompetence, the Board must show Respondent either egregiously deviated from accepted standards of knowledge and expertise on one occasion or deviated in a non-egregious manner from accepted standards on more than one occasion, such that the activity in the aggregate constitutes an egregious deviation from standards.

In the care and treatment of Patient D, the Committee again finds both standards were met. Respondent made no effort to obtain the assistance of the on call pathologist. Respondent chose to deviate from the care plan without any confirmatory consultation. When Respondent performed surgery and found a situation very different from that described by the expert

consultant, he made no effort to affirm his observations. Respondent failed to treat Patient D with appropriate antibiotics before and during the first surgery. Respondent failed to change his choice of antibiotic upon receipt of the cultures. Finally, Respondent admits he failed to file an operative report within the appropriate time frame. When he did write his report, it was incomplete and inaccurate.

In the assessment of this case, the Committee finds six occasions when Respondent acted in a grossly negligent manner:

1. The failure to adhere to the care plan in the absence of a clear basis for same;

2. The failure to arrange for the presence of the on call pathologist prior to surgery;

3. The failure to consult with the on call pathologist when Respondent's observations were extremely different from those of the gastroenterologist.

4. The failure to provide appropriate antibiotic therapy before and during the first surgery.

5. The failure to provide appropriate antibiotic therapy after the cultures were received for the second surgery.

6. The failure to provide a timely and accurate operative report.

At each of these events, Respondent could have made the correct decision and moved within accepted standards of care and diligence. However, he did not. Instead he committed yet another act which was an egregious deviation from standards. Therefore it can be said that Respondent committed six distinct acts which individually, and in the aggregate, constitute an egregious deviation from standards of care and diligence.

The attitude demonstrated in the failure to meet the care standards in Patient D is dangerous in any physician and shows a desire to end the case rather than make a careful

diagnosis. The lack of care and diligence is an extreme deviation from accepted standards and therefore constitutes gross incompetence.

Turning now to Patient E, the Committee does not find any acts of gross incompetence. Again, while the Committee does not endorse the actions of Respondent, they do not rise to the level of gross incompetence.

Therefore:
The Sixth Specification is **SUSTAINED;**
The Seventh Specification is NOT SUSTAINED;

CONCLUSIONS WITH REGARD TO THE EIGHTH SPECIFICATION
(Negligence on More than One Occasion)

Having found Respondent guilty of gross negligence in his care and treatment of Patient D, the Committee has, as a consequence, found Respondent guilty of the lesser included offense of negligence. It is to be noted that there were six separate events upon which the finding of gross negligence and gross incompetence was based. Therefore, the events described also represent six separate acts of negligence and hence, negligence on more than one (six) occasion(s): [8]

1. The failure to adhere to the care plan in the absence of a clear basis for same;

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[8] The Administrative Law Judge ruled that under the relevant case law, (Matter of Rho v Ambach (74 NY2d 318) cited in Matter of Corines v State Board For Professional Medical Conduct (App. Div. 3rd, December 23, 1999)) the Committee could, as a matter of fact, find that the separate acts attributed to each patient could be seen as a separate act or "occasion" of negligence or incompetence.

2. The failure to arrange for the presence of the on call pathologist prior to surgery;

3. The failure to consult with the on call pathologist when Respondent's observations were extremely different from those of the gastroenterologist.

4. The failure to provide appropriate antibiotic therapy before and during the first surgery.

5. The failure to change antibiotic therapy after receipt of the cultures after the second surgery.

6. The failure to produce a timely and accurate operative report.

Turning now to Patient E, the Committee finds Respondent guilty of two acts of negligence. Respondent did not perform a history or physical examination that was consistent with accepted standards of medicine. The prudent practitioner is required to do so. The necessity of a complete examination and history is even more important in a case like that of Patient E because here, the patient enters with significant known medical problems. The precise condition of the patient can only be known after a through examination. Likewise, preparations for complications arising from the known condition can only be made when a complete examination and history is performed.

The second act of negligence is found in the inaccurate and incomplete nature of Respondent's operative report. Practitioners exercising appropriate levels of care and diligence do not leave out the information Respondent did not include in his report. Likewise, a practitioner exhibiting an appropriate level of care and diligence would have provided a description of the surgery which accurately recorded what had occurred. Respondent did not meet this requirement either.

Consistent with the discussion above, it is important to note that the Committee has found two separate and distinct occasions in the care and treatment of Patient E which constitute

negligence. Both the failure to appropriately examine Patient E and record an accurate history plus the failure of Respondent to provide an accurate and complete operative report constitute separate acts which on their own would constitute negligence. In summation, the acts of Respondent with regard to Patient D and the acts of Respondent with regard to Patient E together constitute negligence on more than one occasion. In the same manner, the acts established for each patient separately, constitute negligence on more than one occasion.

Therefore:
The Eighth Specification is **SUSTAINED**.

CONCLUSIONS WITH REGARD TO THE NINTH SPECIFICATION
(Incompetence on More than One Occasion)

Having found Respondent guilty of gross incompetence in his care and treatment of Patient D, the Committee has, as a consequence, found Respondent guilty of the lesser included offense of incompetence. It is to be noted that there were six separate events upon which the finding of gross incompetence was based. Therefore, the events described also represent six separate acts of incompetence and hence, incompetence on more than one (six) occasion(s):

1. The failure to adhere to the care plan in the absence of a clear basis for same;

2. The failure to arrange for the presence of the on call pathologist prior to surgery;

3. The failure to consult with the on call pathologist when Respondent's observations were extremely different from those of the gastroenterologist.

4. The failure to provide appropriate antibiotic therapy before and during the first surgery.

5. The failure to change antibiotic therapy after receipt of the cultures after the second surgery.

6. The failure of Respondent to produce a timely and accurate operative note.

With regard to Patient E, the Committee finds two separate and distinct acts of incompetence. Respondent did not perform a history or physical examination that was consistent with accepted standards of medicine. The competent practitioner is required to do so.

The second act of incompetence is found in the inaccurate and incomplete nature of Respondent's operative report. Practitioners exercising appropriate levels of competence understand that all important information must be included in the patient record. Likewise, a practitioner exhibiting an appropriate level of skill and expertise would have provided a description of the surgery which accurately recorded what had occurred. Respondent did not meet these requirements.

Therefore:
The Ninth Specification is **SUSTAINED**.

CONCLUSIONS WITH REGARD TO THE TENTH AND ELEVENTH SPECIFICATIONS
(Failure to Maintain Accurate Records)

The Committee has set forth its findings regarding the timeliness and quality or Respondent's records. He prepared them late and failed to include important information. While Respondent would have the Committee dismiss the failures demonstrated as insignificant, the Committee will not do so. The records examined in this proceeding with regard to Patient D and

Patient E were extremely poor. They not only lack information, they lack essential information. In some cases it is evident Respondent was not truthful in his presentation. The overall quality of the records in question is so poor that the Committee finds a serious violation of medical standards.

Therefore:
The Tenth Specification is **SUSTAINED;**
The Eleventh Specification is SUSTAINED;

CONCLUSIONS WITH REGARD TO PENALTY

Respondent has shown himself to be morally bankrupt and wanting in fundamental clinical skills. With regard to Patients A, B and C, the issue is not one of sexual conduct or adultery between consenting adults. Rather, the issue before this body is the perversion of the privileges and authority that inure to the holder of a license to practice medicine solely by virtue of that licensure. Respondent used his status as a physician as a tool to obtain personal gratification from women who were his patients. In perverting his standing as a physician, Respondent did not only have a negative effect on the individual patients, he disrupted entire families.

Furthermore, as the facts in this matter become known, first to colleagues and ultimately to the community as a whole, Respondent has hurt his entire profession. Each time a physician betrays the trust bestowed upon him by virtue of his status as a license holder, the public has a right to take notice and wonder at the trustworthiness of all practitioners.

Furthermore, it cannot be overlooked that Respondent defended himself by portraying the three women who testified as liars with destructive agendas behind them. While there was never

any suggestion of force in these relationships and hence, the witnesses acted of their own free will, Respondent sought to protect his standing by attempting to ruin theirs. The fact is that no one in the intrigues established in this proceeding is without blemish. Nevertheless, Respondent must bear the burden of lying to this body at the expense of the three victims.

With regard to the medical issues raised in this proceeding, the mismanagement of Patient D and Patient E would also be grounds for a very serious sanction. With particular regard to Patient D, Respondent displayed a cavalier disregard for some of the most basic tenets of medical care. Worse, when confronted with his failures and shortcomings, rather than admit to error, he developed fabrications that defy medical sense. While a physician who mis manages a patient or commits errors can be rehabilitated, in Respondent's mind, he made no mistakes and provided entirely adequate care. This attitude in a physician is a danger to the community.

If any one of the three patients with whom Respondent engaged in other-than-medical-contact, of a sexual nature, had been the only charge in this proceeding, there would be only one appropriate penalty: revocation. That there were three incidents established shows a pattern of predatory behavior which makes revocation all the more necessary. The addition of Respondent's clinical shortcomings and his attitude about them make the decision to revoke his license a necessity.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

7. It is hereby **ORDERED** that the Factual Allegations in the Statement of Charges (attached to this Decision and Order as Appendix One) are disposed of as follows:

Factual Allegation A IS SUSTAINED;
Factual Allegations A (1.) (a) through A (1.) (f) ARE SUSTAINED;
Factual Allegations A (2.) (a) through A (2.) (i) ARE SUSTAINED;
Factual Allegations A (3.) (a) through A (3.)(c) ARE SUSTAINED;
Factual Allegations A (4.) (a) through A (4.)(e) ARE SUSTAINED;
Factual Allegation B IS SUSTAINED;
Factual Allegations B (1.) (a) through B (1.) (d) ARE SUSTAINED;
Factual Allegations B (2.) (a) through B (2.) (f) ARE SUSTAINED;
Factual Allegations B (3.) (a) through B (3.)(g) ARE SUSTAINED;
Factual Allegations B (4.) (a) through B (4.)(c) ARE SUSTAINED.
Factual Allegation C IS SUSTAINED;
Factual Allegations C (1.) (a) through C (1.) (c) ARE SUSTAINED;
Factual Allegations C (2.) (a) through C (2.) (d) ARE SUSTAINED;
Factual Allegations C (3.) (a) through C (3.)(c) ARE SUSTAINED;
Factual Allegation D IS SUSTAINED;
Factual Allegation D (1.) IS SUSTAINED;
Factual Allegation D (1.) (a) IS SUSTAINED;
Factual Allegation D (1.) (b) WAS WITHDRAWN;
Factual Allegations D (1.) (c) and D (1.) (d) ARE SUSTAINED;
Factual Allegation D (2.) IS SUSTAINED
Factual Allegations D (2.) (a) WAS WITHDRAWN;
Factual Allegations D (2.) (b) and D (2.) (c) ARE SUSTAINED;
Factual Allegation E. IS SUSTAINED;
Factual Allegation E (1.) IS NOT SUSTAINED;
Factual Allegation E (2.) WAS WITHDRAWN;
Factual Allegations E (3.) and E (4.) ARE SUSTAINED;

Furthermore, it is hereby **ORDERED** that;

8. The First, Second, Third, Sixth, Eighth, Ninth, Tenth and Eleventh Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

9. The Fourth, Fifth, and Seventh Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **NOT SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

10. The license of Respondent to practice medicine in the State of New York is **REVOKED**;

Furthermore, it is hereby **ORDERED** that;

11. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: Syracuse, New York

January 10, 2000

KENDRICK A. SEARS, M.D.
Chairperson

JOHN A. MORTON, M.D.
NANCY J. MACINTYRE, R.N., Ph.D.

To: **CINDY M. FASCIA, ESQ.**
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2509
Albany, New York 12237

MICHAEL L. KOENIG, Esq.
PAMELA A. NICHOLS, Esq.
O'Connell and Aronowitz
100 State Street
Albany, New York, 12207

STEVEN ST. LUCIA, M.D.
Schenectady Surgical Care Assoc.
624 McClellan St. Suite402
Schenectady NY 12304

APPENDIX ONE

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	NOTICE
OF	:	OF
STEVEN ST. LUCIA, M.D.	:	HEARING

----------X

TO: Steven St. Lucia, M.D.
Schenectady Surgical Care Associates
624 McClellan Street, Suite 202
Schenectady, New York 12304

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 24th day of February, 1999, at 10:00 in the forenoon of that day at the Hedley Park Place, 433 River Street, 6th Floor, Troy, New York 12180-2299, 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 Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), 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(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy 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 DETERMINATION 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. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 3, 1999

WILLIAM J. COMISKEY
Counsel

Inquiries should be directed to:

Cindy M. Fascia
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
STEVEN ST. LUCIA, M.D.	:	CHARGES

----------X

STEVEN ST. LUCIA, M.D., the Respondent, was authorized to practice medicine in New York State on March 17, 1993 by the issuance of license number 191715 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period through October 31, 2000, with a registration address of Schenectady Surgical Care Associates, Suite 202, 624 McClellan Street, Schenectady, New York 12304.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [patients are identified in Appendix] on various occasions from on or about August 8, 1997 through on or about September 30, 1997 at Respondent's office at 624 McClellan Street, Schenectady, New York [hereinafter office at St. Clare's Hospital.] Respondent, on or about August 21, 1997, performed surgery on Patient A at St. Clare's Hospital, Schenectady, New York. Respondent on that date performed a sigmoid resection with primary anastomosis and lysis of adhesions. Patient A's gynecologist on that date had also performed a total abdominal hysterectomy, left salpingo-

oophorectomy, and lysis of adhesions.

1. Respondent, on or about September 6, 1997, during Patient A's visit for medical care at Respondent's St. Clare Hospital office, engaged in the following conduct including without limitation:

a) Respondent told Patient A that he was attracted to her and/or felt a strong connection to her or words to such effect.

b) Respondent told Patient A that he and his wife had separated more than once and/or had been in marital counseling or words to such effect.

c) Respondent told Patient A that she was beautiful or words to such effect.

d) Respondent told Patient A that he loved the way she smelled, or words to such effect.

e) Respondent hugged Patient A.

f) Respondent kissed Patient A on the mouth.

2. Respondent, on or about September 7,1997, during the period of time in which he was providing medical care to Patient A, met Patient A at his office at St. Clare's Hospital. Respondent engaged in the following conduct, including without limitation:

a) Respondent hugged Patient A and kissed Patient A on the mouth.

b) Respondent told Patient A that she was sexy or words to such effect.

c) Respondent told Patient A that he and she would make a beautiful couple, or words to such effect.

d) Respondent unfastened Patient A's pants and

without limitation:

a) Respondent performed oral sex on Patient A.

b) Respondent had sexual intercourse with Patient A.

c) Respondent engaged in digital intercourse with Patient A.

d) Respondent, when asked by Patient A whether it was safe for them to have unprotected sexual intercourse, said "of course. Do you think I do this with everyone?" or words to such effect.

e) Respondent engaged in sexual intercourse with Patient A less than one month after Patient A had undergone major surgery.

B. Respondent provided medical care to Patient B on various occasions from on or about March 13, 1997 through on or about July 28, 1997 at Respondent's office at St. Clare's Hospital and/or Respondent's office located at 1201 Nott Street, Schenectady [hereinafter "office at Ellis Hospital"] and/or at St. Clare's Hospital, where Respondent performed surgery on Patient B on or about May 15, 1997.

1. Respondent, during the period of time that he was providing medical care to Patient B, engaged in telephone conversations with Patient B which had no valid medical purpose and/or which calls related to Respondent being attracted to Patient B and/or pursuing a personal relationship with Patient B. Respondent, during said telephone conversations, engaged in the following conduct, including without limitation:

a) Respondent acknowledged flirting with

pulled them down.

e) Respondent told Patient A that her surgical scar didn't bother him at all, or words to such effect, when Respondent knew that Patient A, prior to surgery, had expressed concern about her surgical scars.

f) Respondent asked Patient A to let him finger her or words to such effect.

g) Respondent asked Patient A to let him "taste" her or words to such effect.

h) Respondent touched Patient A's vaginal area with his fingers and then put his fingers to his lips.

i) Respondent asked Patient A to "taste" him or words to such effect.

3. Respondent, on or about September 9 or 10, 1997, during the period of time in which he was providing medical care to Patient A, arranged with Patient A to meet at the Plotterkill Preserve, for purposes of pursuing a personal and/or sexual relationship with Patient A, and not for providing medical care. Respondent, during the course of that meeting, engaged in the following conduct, including without limitation:

a) Respondent, while sitting in his car with Patient A at the Plotterkill Preserve, hugged and kissed Patient A.

b) Respondent asked Patient A to unbutton and/or remove her sweater.

c) Respondent asked Patient A to recline the car seat on which she was sitting.

4. Respondent, on or about September 16, 1997, arranged to meet Patient A at the L&M Motel in Schenectady, New York. Respondent, during the course of that meeting, engaged in sexual intercourse and other sexual contact with Patient A, including

Patient B.

b) Respondent told Patient B that she had "the most beautiful brown eyes he had ever seen" or words to such effect.

c) Respondent, when Patient B expressed anxiety about their developing relationship, told Patient B "It sounds like what you need is a doctor" or words to such effect.

d) Respondent told Patient B that he needed a friend, or words to such effect.

2. Respondent, during Patient B's office visit for medical care to Respondent's office at St. Clare's Hospital on or about May 22, 1997, engaged in the following conduct:

a) Respondent stated, referring to Patient B's wrap-around skirt, "Oh, I love that skirt, and it opens" or words to such effect..

b) Respondent told Patient B he gave good massages and that she should let him know if she was interested or words to such effect.

c) Respondent told Patient B that he was under stress and had problems in his personal life or words to such effect.

d) Respondent told Patient B that he loved her smile and/or that she made him laugh and/or and that he felt comfortable with her or words to such effect.

e) Respondent, when Patient B asked him if he had other patients to see that day, said he would like to spend the whole afternoon with her or words to such effect.

f) Respondent told Patient B that he would bring her in to the office every day if he could or words to such effect.

3. Respondent, on or about Sunday, June 1, 1997, and during the period of time when Respondent was providing medical care to Patient B, arranged to meet Patient B at his office at

St. Clare's Hospital for purposes of pursuing a personal and/or sexual relationship with Patient B, and not for providing medical care. Respondent, during the course of that meeting, engaged in the following conduct, including without limitation:

a) Respondent told Patient B about problems in his personal life, including that he and his wife had been separated more than once and/or had gone to counseling or words to such effect.

b) Respondent touched Patient B's hands and told her that he loved her hands or words to such effect.

c) Respondent massaged Patient B's legs.

d) Respondent, when Patient B asked him what they would do if someone walked in on them in the office, said "I'll just say I'm examining your leg" or words to such effect.

e) Respondent told Patient B that she had beautiful eyes and a beautiful smile or words to such effect.

f) Respondent hugged Patient B.

g) Respondent kissed Patient B on the mouth.

4. Respondent, on or about Saturday, June 14, 1997, and during the period of time in which he was providing medical care to Patient B, arranged to meet Patient B at his office at St. Clare's Hospital for purposes of pursuing a personal and/or sexual relationship with Patient B, and not for providing medical care. Respondent, during said meeting, engaged in the following conduct, including without limitation:

a) Respondent told Patient B that he loved the way she dressed, and/or that she was beautiful and sexy, or words to such effect.

b) Respondent kissed Patient B on the mouth.

c) Respondent performed oral sex on Patient B on an examination table in Respondent's office.

C. Respondent provided medical care to Patient C on various occasions from on or about July 10, 1995 through on or about September 1997 at Respondent's office at St. Clare's Hospital.

1. Respondent, on various occasions during the period of time in 1997 in which he treated Patient C, made sexually suggestive statements to Patient C including but not limited to the following:

a) Respondent told Patient C that she should quit smoking and replace it with another type of oral fixation or words to such effect.

b) Respondent told Patient C that even though she was ten years younger than he, that she "didn't know what she was in for and that he could handle her" or words to such effect.

c) Respondent made a bet with Patient C that she could not quit smoking and if Respondent won the bet he could take Patient C anywhere and do whatever he wanted to her, or words to such effect.

2. Respondent, on or about Saturday, August 2, 1997, met Patient C at his office at St. Clare's Hospital and engaged in the following conduct:

a) Respondent massaged Patient C's neck, shoulders, face and head.

b) Respondent kissed Patient C on the mouth.

c) Respondent put his hands inside the legs of Patient C's shorts.

d) Respondent, when Patient C asked if he relaxed all his patients this way, said he did not, that this was special, and that he

felt so comfortable with her and connected with her, or words to such effect.

3. Respondent, on or about Saturday, August 16, 1997, met with Patient C at his office at St. Clare's Hospital. Respondent engaged in the following conduct:

a) Respondent kissed Patient C on the mouth.

b) Respondent, when Patient C said that she needed his support and friendship because she was going to undertake genetic testing due to her family history of breast cancer, told Patient C "I'm not a fucking psychiatrist, I'm a fucking surgeon" or words to such effect.

c) Respondent tried to kiss Patient C again.

D. Respondent provided medical care to Patient D from approximately September 21, 1995 through October 15, 1995 at St. Clare's Hospital.

1. Respondent, on or about September 22, 1995, performed surgery on Patient D. Respondent described said surgery as an exploratory laparotomy and oversewing of bleeding ulcer.

a) Respondent performed inappropriate surgery on Patient D and/or failed to perform a gastrectomy.

b) Respondent failed to order and/or administer pre and/or peri-operative and/or post-operative antibiotics for Patient D.

c) Respondent failed to obtain a frozen section diagnosis.

d) Respondent failed to do a timely and/or adequate operative report for this procedure.

2. Respondent, on or about September 25, 1995, again performed surgery on Patient D. Respondent described said surgery as an exploratory laparotomy, subtotal gastrectomy, Billroth II, debridement of fascia, and insertion of a gastrostomy tube.

a) Respondent failed to perform adequate debridement and/or to adequately document the debridement he performed.

b) Respondent failed to timely order adequate antibiotic therapy post-operatively.

c) Respondent failed to do a timely and/or adequate operative report for this procedure.

E. Respondent provided medical care to Patient E from approximately October 3, 1995 through approximately October 10, 1995 at St. Clare's Hospital. Respondent, on October 3, 1995, performed an insertion of a Porta-Cath in the subclavian vein on Patient E.

1. Respondent used an inappropriate surgical approach to perform this procedure on Patient E, and/or failed to address Patient E's thrombocytopenia prior to attempting blind percutaneous placement of the subclavian line.

2. Respondent failed to use fluoroscopy when attempting percutaneous placement of the subclavian line.

3. Respondent failed to perform and/or document performance of an adequate history and/or physical examination and/or pre-operative workup of Patient E.

4. Respondent failed to do a timely and/or adequate operative report.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with professional misconduct by reason of his committing conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20) (McKinney's Supp. 1997), in that Petitioner charges:

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

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

3. The facts in Paragraphs C and C.1(a), and/or C.1(b), and/or C.1(c), and/or C.2(a), and/or C.2(b), and/or C.2(c), and/or C.2(d), and/or C.3(a), and/or C.3(b), and C.3(c).

FOURTH AND FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing medicine with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

4. The facts in Paragraphs D and D.1(a) and/or D.1(b) and/or D.1(c) and/or D.1(d) and/or D.2(a) and/or D.2(b).

5. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3.

SIXTH AND SEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing medicine with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

6. The facts in Paragraphs D and D.1(a) and/or D.1(b) and/or D.1(c) and/or D.1(d) and/or D.2(a) and/or D.2(b).

7. The facts in Paragraphs E and E.1 and/or E.2 and/or E.3.

EIGHTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3), that Petitioner charges that Respondent committed two or more of the following:

8. The facts in Paragraphs D and D.1(a) and/or D.1(b) and/or D.1(c) and/or D.1(d) and/or D.2(a) and/or D.2(b) and/or E and E.1 and/or E.2 and/or E.3.

NINTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges:

9. The facts in Paragraphs D and D.1(a) and/or D.1(b) and/or D.1(c) and/or D.1(d) and/or D.2(a) and/or D.2(b) and/or E and E.1 and/or E.2 and/or E.3.

TENTH AND ELEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct under New York Education Law §6530(32) by reason of his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

10. The facts in Paragraphs D and D.1(d) and/or D.2(a) and/or D.2(c)

11. The facts in Paragraphs E and E(3) and/or E(4).

DATED: February 3, 1998
Albany, New York

WILLIAM J. COMISKEY
Counsel
Bureau of Professional
Medical Conduct

APPENDIX TWO

1001

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

In the Matter of

STEVEN ST. LUCIA, M.D.

RESPONDENT'S ANSWER

STEVEN ST. LUCIA, M.D., by and through his attorneys, O'Connell and Aronowitz (Michael L. Koenig, Esq., and Pamela A. Nichols, Esq. of Counsel), hereby answer the Charges and Allegations set forth in the February 3, 1999 Statement of Charges:

FACTUAL ALLEGATIONS

A. Admits that he provided medical care to Patient A, [redacted], on occasions in August and September 1998 and admits that he performed surgery on this individual on or about August 21, 1997. Dr. St. Lucia denies sufficient knowledge to respond to what procedure Patient A's gynecologist performed.

1. (a)-(f) Denies each and every allegation.

2. (a)-(i) Denies each and every allegation.

3. Denies arranging to meet with Patient A for the purposes of pursuing a personal and/or sexual relationship.

(a)-(c) Denies each and every allegation.

4. Denies meeting Patient A at the L&M Hotel.

(a)-(e) Denies each and every allegation.

B. Admits that he provided medical care to Patient B, [redacted], on occasions between March and July 1997, and admits that he performed surgery on Patient B on or about May 15, 1997.

1. Denies that he engaged in telephone conversations with Patient B which had no valid medical purpose and/or related to a personal relationship with, or being attracted to, Patient B.

(a)-(d) Denies each and every allegation.

2. (a)-(f) Denies each and every allegation.

3. Denies arranging to meet Patient B at his office at St. Clare's Hospital for purposes of pursuing a personal and/or sexual relationship.

(a)-(g) Denies each and every allegation.

4. Denies that he arranged to meet Patient B on Saturday, June 14, 1997, for the purposes of pursuing a personal and/or sexual relationship.

(a)-(c) Denies each and every allegation.

C. Admits that he provided medical care to Patient C, [redacted], on occasions between July 1995 and September 1997.

1. Denies that he made sexually suggestive statements to Patient C in 1997.

(a)-(c) Denies each and every allegation.

2. (a)-(c) Denies each and every allegation.

3. (a)-(c) Denies each and every allegation.

D. Admits that he provided medical care to Patient D, [redacted] between approximately September 21, 1995 through October 15, 1995.

1. Admits that he performed surgery on Patient D on or about September 22, 1995.

(a)-(d) Denies each and every allegation.

2. Admits that he performed surgery on Patient D on September 25, 1995.

(a)-(c) Denies each and every allegation.

E. Admits that he provided medical care to Patient E, [redacted] between approximately October 3, 1995 through October 10, 1995.

1. Denies.

2. Denies.

3. Denies.

4. Denies.

Please be advised that Dr. St. Lucia will move to preclude any allegations not specifically contained in the Statement of Charges. Specifically, throughout the Statement of Charges appears the term "including without limitation." This is vague and impossible to defend against. Accordingly, any evidence or proof the State intends to introduce that is not specifically set forth should be precluded.

SPECIFICATION OF CHARGES

1. Denies.

2. Denies.

3. Denies.

4. Denies.

5. Denies.

6. Denies.

7. Denies.

8. Denies.

9. Denies.

10. Denies.

11. Denies.

DATED: February 12, 1999

O'CONNELL AND ARONOWITZ
By:

Michael L. Koenig, Esq.
Attorneys for Respondent
Office and P.O. Address
100 State Street
Albany NY 12207-1885
(518) 462-5601

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