STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

September 26, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Emanuel Falcone, M.D.
[redacted]

Jean Bresler, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, New York 10801

Michael S. Kelton, Esq.
Michael S. Kelton & Associates LLC
630 Third Avenue, 5th Floor
New York, New York 10017

RE: In the Matter of Emanuel Falcone, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-186) 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 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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,

James F. Horan, Acting Director
Bureau of Adjudication

JFH:nm

Enclosure

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

IN THE MATTER

OF

EMANUEL FALCONE, M.D.

DETERMINATION
AND
ORDER

BPMC 08 -186

Patrick F. Carone, M.D., M.P.H., (Chairperson), Diane M. Sixsmith, M.D., and Henry Sikorski, Ph.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law (**P.H.L.**). Marc P. Zylberberg, Esq., Administrative Law Judge, (**ALJ**) served as Administrative Officer.

The Department of Health (**Department**) appeared by Jean Bresler, Esq., Associate Counsel. Emanuel Falcone M.D. (**Respondent**) appeared personally and was represented by Michael S. Kelton & Associates, LLC, Michael S. Kelton, Esq., of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges: February 26, 2008

Date of Answer to Charges: March 12, 2008

Pre-Hearing Conferences Held:	March 19, 2008 April 4, 2008
Hearings Held: - (First Hearing day):	April 4, 2008 May 28, 2008 June 24, 2008 July 14, 2008 August 11, 2008
Intra-Hearing Conferences Held:	May 28, 2008 June 24, 2008 July 14, 2008 August 11, 2008
Location of Hearings:	Offices of New York State Department of Health 90 Church St., 4th Floor New York, NY 10007
Witnesses called by the Department of Health: (in the order they testified)	Karen Hopenwasser, M.D. (alleged) Patient A[1] [redacted], Ph.D.
Witnesses called by Emanuel Falcone, M.D.: (in the order they testified)	June Burstein, LCSW Emanuel Falcone, M.D. Michael F. McNally Scott Oskow-Schoenbrod Moses Weksler, Ph.D. Giovanny Nunez, M.D.
Department of Health's Proposed Findings of Fact and Conclusions of Law and Credibility Argument:	Received September 3, 2008
Respondent's Proposed Findings of Fact and Conclusions of Law:	Received September 3, 2008
Deliberations Held: (last day of Hearing)	Monday, September 22, 2008

[1] The record and this Determination and Order refers to the patient or alleged patient by letter to protect patient privacy. Alleged Patient A is identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1).

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**Petitioner** or **Department**) pursuant to §230 of the P.H.L.

Emanuel Falcone, M.D. (**Respondent**) is charged with seven (7) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York (**Education Law**).

Respondent is charged with professional misconduct by reason of: (1) engaging in physical contact of a sexual nature between the licensee (a psychiatrist) and a patient in the practice of psychiatry[2]; (2) engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice[3]; (3) practicing the profession of medicine with negligence on more than one occasion[4]; (4) practicing the profession with gross negligence[5]; (5) practicing the profession with incompetence on more than one occasion[6]; (6) practicing the profession with gross incompetence[7]; and (7) failing to maintain a record for a patient which accurately reflected the evaluation and treatment of the patient[8].

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[2] Education Law §6530(44)(a) - (First Specification of the Statement of Charges; [Department's Exhibit # 1].

[3] Education Law §6530(20) - (Second Specification in the Statement of Charges); [Department's Exhibit # 1].

[4] Education Law §6530(3) - (Third Specification in the Statement of Charges); [Department's Exhibit # 1].

[5] Education Law §6530(4) - (Fourth Specification of the Statement of Charges; [Department's Exhibit # 1].

[6] Education Law §6530(5) - (Fifth Specification of the Statement of Charges; [Department's Exhibit # 1].

[7] Education Law §6530(6) - (Sixth Specification of the Statement of Charges; [Department's Exhibit # 1].

[8] Education Law §6530(32) - (Seventh Specification of the Statement of Charges; [Department's Exhibit # 1].

The Factual Allegations, Charges, and Specifications of professional misconduct result from Respondent's alleged conduct towards one (alleged) patient from 2003 through 2006.

Respondent denies that the person identified as (alleged) Patient A was a psychiatric patient of Respondent's, denies that he engaged in the practice of medicine in his interactions with alleged Patient A, and denies that he ever treated alleged Patient A. Respondent admits that he engaged in sexual contact with the person identified as Patient A (in the appendix A of the Statement of Charges) during the year 2006, and admits that he did not maintain a medical record for alleged Patient A.

Respondent denies all other factual allegations and all specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges is attached to this Determination and Order as Appendix 1. A copy of Respondent's Answer is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following Findings of Fact (**Findings**) were made after a review of the entire record available to the Hearing Committee in this matter. These Findings represent documentary evidence and testimony found persuasive by the Hearing Committee. Where there was conflicting evidence, the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable, or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed with all Findings. All Findings were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on July 22, 1985 by the issuance of license number 163401 by the New York State Education Department (Admitted); (Respondent's Exhibits # A, # F, and # G).

2. Respondent was Board Certified in General Psychiatry in October 1990 and Board Certified in Child and Adolescent Psychiatry in September 1991. Respondent also obtained a Florida license in February 2005 (Respondent's Exhibits # F and # G).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's New York license and this disciplinary proceeding (NOTE: determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); [P.H.T-19-21][9]; (Department Exhibit #1).

4. Starting in 2003, alleged Patient A (hereinafter Patient A) began treatment with June Burstein, a New York State licensed clinical social worker. Patient A met with Ms. Burstein, at first once or twice a week, and then three to four times per week, in Ms. Burstein's Manhattan office, until June 2005 when Ms. Burstein and Respondent left New York State and relocated to Florida [T-179-180, 392, 583, 722]; (Respondent's Exhibit # E).

5. When Patient A began treatment with Ms. Burstein, Patient A had not yet been diagnosed with Dissociative Identity Disorder ("**DID**" [formerly known as multiple personality disorder]). In the beginning of their professional relationship, Patient A would communicate with Ms. Burstein by writing a daily journal, which she would present to Ms. Burstein on each office visit [T-181, 392-393, 585-587].

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[9] Numbers in brackets refer to Hearing transcript page numbers [T-], or to Pre-Hearing transcript page numbers [P.H.T-], or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee was not present at, and did not review, the Pre-Hearing transcripts or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

6. On at least one occasion (in 2005 or earlier) during Patient A's treatment with Ms Burstein, Ms. Burstein showed some of Patient A's daily journal writings to Respondent. Respondent reviewed Patient A's daily journal writings and subsequently told Patient A that it was he and not Ms. Burstein who made the diagnosis of DID and that he made the diagnosis from reading the writings she gave to Ms. Burstein [T-191-192, 451-453, 723-730, 732-733, 889-890, 992].

7. From approximately 1996 through April 2005, Ms. Burstein and Respondent lived together, except for a period of approximately 2 years in the late 1990's. In April 2005, Ms. Burstein and Respondent married [T-583-584, 722-723].

8. In addition to reading Patient A's journal writings, Respondent discussed Patient A's treatment with Ms. Burstein and provided Ms. Burstein assistance in the handling of Patient A (Department's Exhibit # 11); [T-281-283].

9. On one occasion, Patient A was not able to reach Ms. Burstein. As a result Ms. Burstein gave Patient A a beeper number. She advised Patient A that the number belonged to a psychiatrist named Dr. Falcone who was her back up. Thereafter, on several occasions, Patient A called the beeper number she was given and each time Ms. Burstein returned her call [T-178-179].

10. In June 2005, during a therapy session, Ms. Burstein told Patient A that Dr. Falcone was her husband and that he had suffered a heart attack. Patient A (as alter , made a drawing and get well card for Ms. Burstein to give to Dr. Falcone which she did [T-190, 600, 749].

11. Ms. Burstein brought the get well card, prepared by to the hospital and showed it to Respondent. Respondent thought it was a sweet and cheering gesture. The card was addressed to "Mr. Manny" (Respondent Emanuel Falcone is also known as Manny) [T-750, 883-886].

12. One characteristic of DID is the emergence of alters which are "state " changes that are manifested by distinct patterns of mood, cognition, memory, and behavior. Alters appear as a result of trauma. A very traumatized child often creates a part of themselves to deal with the trauma. The traumatized child who grows into a traumatized adult retains the alters within themselves and rather then that young child part becoming a memory the young child part remains an identity that can act and feel and relate to people as if the adult were a child. Patient A has several alters or self states and is one of them [T-47-49, 76].

13. On June 26, 2005, Respondent and his wife, June Burstein, moved to Florida [T-744].

14. The professional relationship between Ms. Burstein and Patient A continued even after Ms. Burstein moved to Florida (Department's Exhibits # # 2-B, # 6, # 7, # 12, and, # 13); [T-91-92, 163-164, 186-187].

15. Between July 2005 and December 2005 hundreds of telephone calls were made between Patient A and the Falcone residences[10] (Department's Exhibits # 12 and # 13).

16. A number of calls were made by Patient A to Respondent's office and cell phone number (Department's Exhibit # 13). Between July and December 2005, Respondent spoke to Patient A at least a dozen times from his cell phone [T-760]; (Department's Exhibit # 12 and # 13).

17. Between July 2005 and December 2005, during some of the phone calls by Patient A to the various Falcone residences, Respondent admitted he spoke to Patient A, and occasionally to some of her alters [T-425, 760, 201-203, 764].

18. Approximately September of 2005, Respondent sent toys and began speaking with on the telephone [T-775-776, 790, 883, 932-934].

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[10] When they first moved to Florida, Respondent and Ms. Burstein lived in an apartment and then moved to a house around September of 2005 [T-790].

19. After moving to Florida Respondent began communicating with the child alters over the telephone first by speaking to and then to the other child alters. When patient A was in distress Respondent intervened and communicated with the child alters to treat Patient A's symptoms of anxiety, panic, depression, and thoughts of suicide. As

Respondent stepped in to assume an even more active role as Patient A's therapist [T-204-206, 440-443].

20. When Patient A presented with a crisis that Ms. Burstein was unable to handle Respondent would take the phone and intervene. Initially it was with and later Respondent did the same with Patient A's other alters (Department's Exhibit # 11); [T-284]; (see also Findings # 19 above).

21. Respondent told a friend of Patient A that he had made the diagnosis of DID in regard to Patient A [T-497, 731-736].

22. Respondent told Dr. (Patient A's treating psychologist) that he had made the diagnosis of DID in regard to Patient A [T-890, 992]; (Department's Exhibit # 11).

23. In December 2005, Patient A went to Florida to visit Ms. Burstein and Respondent. Patient A stayed at their home [T-446-449, 604-605, 774].

24. During this first December 2005 trip, Ms. Burstein and Respondent took Patient A on various outings including a wildlife preserve and to play miniature golf. Respondent actively engaged the alters by addressing their fears and anxieties and providing gifts and outings for each of them (Department's Exhibits # 2-A through 2-I); [T-212, 606-607]

25. Patient A returned to the Falcone's Florida home for a second visit during the period from Christmas 2005 to the New Year (2006). On this trip, Patient A brought Respondent a drawing of a "restful scene". During this second visit, Patient A and Respondent discussed getting together when both would be in New York later in January of 2006 [T-751-753, 794].

26. In January 2006, while Patient A was visiting New York for dental work, and Respondent was visiting New York to see his children, Patient A and Respondent had sexual relations [T-227, 456, 802, 973]; (Admitted).

27. Patient A made another trip to Florida in February 2006, this time to see Respondent. Patient A and Respondent spent a weekend at Sanibel-Captiva Island, and engaged in sexual relations [T-456-457, 807-808, 973].

28. Respondent called in a prescription for Triamcinolone (a topical ointment used to treat psoriasis) to Patient A's pharmacy after Patient A had returned to Massachusetts in February 2006 (Department's Exhibit # 3); [T-813-817].

29. Respondent admitted that he did not maintain a medical record for Patient A (Admitted); (Respondent's Exhibit # A); [T-999-1002].

30. Respondent should have maintained a medical record for Patient A for the prescribing of Triamcinolone and for the psychiatric evaluation, diagnosing, and treatment of Patient A [T-89].

CONCLUSIONS OF LAW

The Hearing Committee makes the conclusions that the following Factual Allegations contained in the February 26, 2008 Statement of Charges are **SUSTAINED**:

Factual Allegations A.1., and A.3 are sustained as written. Factual Allegation A. and A.2. are sustained as follows:

A. From approximately the Spring of 2005 through sometime in 2006, Respondent engaged in the practice of medicine in his interactions with Patient A (identified in attached Appendix), a psychiatric patient. Respondent failed to meet accepted standards of medical practice, in that:

2. Throughout the period of Spring 2005 through sometime in 2006, Respondent treated Patient A, a patient with Dissociative Identity Disorder, in an inappropriate manner.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee unanimously concludes that all seven (7) Specifications of Misconduct contained in the Statement of Charges are **SUSTAINED**.

A further explanation of the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with seven (7) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

The practice of medicine or psychiatry

1. The question of whether a physician's conduct occurred in the course of a physician-patient relationship is a factual one to be resolved by the Hearing Committee.

Section 6521 of the Education Law lists the behaviors which constitute the practice of medicine: Definition of practice of medicine. The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.

Preponderance of the Evidence

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the Charges by a preponderance of the evidence.

Moral Unfitness

3. To sustain a specification of moral unfitness, the Department must show that Respondent committed an act or acts which "evidences moral unfitness". The act or acts must be "conduct in the practice of the profession of medicine". Moral unfitness in the practice of medicine constitutes either a violation of the public trust bestowed by virtue of the physician's license as a physician or a violation of the moral standards of the medical community. 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 Hearing Committee is asked to decide if certain conduct is suggestive of, or would tend to prove, moral unfitness. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

Gross Negligence

4. Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct. The term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Negligence on More Than One Occasion

5. Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by Dr. Falcone caused actual harm to a patient.

Gross Incompetence

6. Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

Incompetence on More Than One Occasion

7. Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning.

Failure to Maintain Records

8. A physician must record meaningful and accurate information in a patient's medical records which accurately reflects the care and treatment of the patient for a number of reasons. These reasons include: (1) the physician's own use; (2) the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient.

Witness Testimony

9. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

The Hearing Committee used common English usage and understanding for all terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, and/or demeanor.

Credibility Determination

The Hearing Committee found the expert witness presented by the Department, Karen Hopenwasser, M.D. to be credible and unbiased. Dr. Hopenwasser testified in a direct manner regarding the records she reviewed and the standard of care required.

Ph.D. is one of Patient A's treating therapist for the past 3 years. Dr. has no personal interest in this proceeding. She is a well recognized and respected professional in her field. She had four authorized telephone conversations with Respondent. One occurred only between her and Respondent. The other three were conference calls which included Patient A and Respondent. Dr. records documenting those phone conversations, at times, contradict the recollection of Respondent. The Hearing Committee finds records to be more reliable than Respondent's memory.

June Burstein, LCSW, testified on behalf of Respondent. Respondent himself questioned the credibility of his wife. Ms. Burstein's self-interest was only eclipsed by that of her husband. The Hearing Committee gave very little weight to her testimony.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Respondent is articulate and is able to explain and justify to himself that what he has done is not what it appears to be, and therefore did not occur.

Respondent's own testimony was sufficient to sustain the charges brought against him by the Department. Respondent admitted to seeing Patient A's writings, admitted that he told three (3) individuals that he made the diagnosis of DID, admitted that he engaged (evaluated) Patient A's "alters"; acknowledged that by engaging the alters he was providing treatment (admittedly very bad treatment or counter treatment [T-1001, 1018-1019]); admitted having sexual relationship with Patient A; and admitted that he prescribed a medication to Patient A.

The Hearing Committee found Respondent to be a selfish individual without evidence of remorse. Respondent showed a total lack of compassion or regret both for Patient A and for his wife.

Patient A's testimony was consistent with her medical records and the testimony of the other witnesses presented by the Department. The Hearing Committee found her testimony to be credible and sincere.

Although Patient A never formerly engaged Respondent as her physician, she was, in effect, referred to him by Ms. Burstein and Patient A enthusiastically accepted and trusted Respondent. The definition of the practice of medicine does not require that a fee be paid in exchange for professional services. Nor is there a requirement that evaluation, treatment or prescribing occur in an office or in a medical/hospital setting or as a formal therapy session.

SUMMARY

1. Respondent is charged with committing professional misconduct under Education Law §6530(44)(a) by engaging in physical contact of a sexual nature between the licensee and the patient in the practice of psychiatry.

Respondent engaged in a physician-patient relationship with Patient A. Respondent evaluated or examined Patient A by reading her daily journal writings (treatment records), exchanging gifts, and through telephone treatment sessions with Patient A. Respondent diagnosed Patient A with Dissociative Identity Disorder. Respondent became enthralled with his diagnosis of Patient A and fascinated with her alters. Respondent's treatment of Patient A began when Patient A, devastated by her separation from Ms. Burstein, began to deteriorate rapidly.

The critical phone call when Respondent engaged ' to calm down Patient A was a therapist's intervention and the beginning of Respondent's slide down the slippery slope of attempting to establish a therapeutic relationship. Ms Burstein, unable to manage Patient A's increasing symptoms, either requested or passively allowed Respondent to step in and manage Patient A. This occurred initially over the telephone and continued when Patient A began visiting Ms. Burstein and Respondent in Florida. When a psychiatrist takes over for another therapist he creates a psychiatrist-patient relationship. Respondent provided substantial verbal and behavioral psychological interventions in his interactions with Patient A. On numerous occasion on the telephone, Respondent attempted to modify Patient A's behavior for the purpose of preventing or eliminating her symptomatic, maladaptive or undesired behavior (including talking to ' eparately).

Respondent's expertise as a psychiatrist (Board Certified in General Psychiatry and in Child and Adolescent Psychiatry) gave meaning to the information he obtained from reading Patient A's writings, examining her drawings, and interacting with the (child) alters. His training and knowledge as a psychiatrist gave him meaningful access. To a trained psychiatrist the behavior, drawings and writings evidences illness and vulnerability. Respondent knew that Patient A was vulnerable and he eventually exploited that vulnerability for his own purpose and satisfaction.

The Hearing Committee has no doubt that Respondent's actions were voluntary, knowing and willful. Respondent claims that he never considered himself to have established a psychiatrist-patient or psychotherapeutic relationship with Patient A but that may have been only because he was so captivated by exploring the patient's diagnosis, personality and intelligence. Respondent also claims that he never considered or intended any of the numerous conversations with Patient A or her alters to constitute psychiatric treatment or therapy. The Hearing Committee does not rely on Respondent's claimed considerations, claimed beliefs, or claimed intentions.

Respondent claims that he never considered any of his interactions with Patient A to be psychiatric treatment or therapy. Respondent claims that he never considered himself to be a part of Patient A's "therapy team". Respondent claims he always considered his relationship with Patient A to be a purely personal friendship, developed through Patient A's connection to Ms. Burstein, which became, over time, romantic in nature. The fact is that Respondent never considered Patient A as a patient because he was too selfishly motivated and lost sight of his oath to "first do no harm". The fact is that Respondent refused to consider and confront the reality when tried to remind him of his responsibilities. The fact is that Respondent reluctantly agreed to pay (for continuation of treatment of Patient A) for the egregious harm that he had caused Patient A only after Patient A made threats against him. The fact is that the payments made were few and stopped quickly. The fact is that Respondent issued a prescription to Patient A.

Respondent, while in the practice of psychiatry, engaged in a sexual relationship with his patient. Respondent committed professional misconduct under Education Law §6530(44)(a). The First Specification of professional misconduct is sustained.

2. Respondent is charged with committing professional misconduct under Education Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice.

Without Patient A's consent Respondent violated Patient A's confidentiality by reviewing writings which she prepared for purposes of treatment by Ms. Burstein. Respondent repeatedly affirmed and reaffirmed the DID diagnosis to Patient A and to others. Along with Ms. Burstein, Respondent engaged in the intentional blurring of professional boundaries with Patient A by: on the one hand rendering a psychiatric diagnosis and offering treatment, and on the other hand sending gifts to Patient A, accepting gifts (including expensive hotel accommodations) from Patient A and providing special events for Patient A's child alters (as well as for Patient A herself). Respondent's manipulative and destructive relationship with Patient A kept her from receiving the appropriate psychiatric care that should have been available to her. Respondent prescribed a medication to Patient A in February 2006. Respondent engaged in a sexual relationship with Patient A in January and February 2006.

Respondent's conduct toward Patient A constituted conduct in the practice of medicine evidencing moral unfitness. Respondent violated the public trust provided to physicians by engaging in a sexual relationship with a patient while in the practice of medicine. Respondent committed professional misconduct under Education Law §6530(20). The Second Specification of professional misconduct is sustained.

3. Respondent is charged with committing professional misconduct under Education Law §6530(3) and §6530(4) by practicing the profession of medicine with negligence on more than one occasion and by practicing the profession of medicine with gross negligence on a particular occasion.

Respondent seriously deviated from accepted standard of care by inappropriately treating the alters on numerous occasions, as if they were separate beings. Generally, the goal of treatment would have been to encourage a patient to see alters as memory states and not as separate states of self.

It was a gross deviation from accepted standard of care and inappropriate to give gifts to Patient A because of the transference and counter transference which are always part of the therapeutic relationship. Sending gifts to DID patients presents special problems as it is important to not give the DID patient the message that they are special. Making the patient special is repetitive of the DID patient's childhood relationship to the abuser. In addition, singling out alters for special gifts or special treatment not only reinforces the "specialness" of the patient, it cements the alter as a separate self. It was a gross deviation and a willful disregard for her well-being to have sexual relations with patient A. Respondent's repeated telephone therapy which drew out Patient A's "alters" constitutes negligence on more than one occasion.

Respondent committed professional misconduct under Education Law §6530(3) and §6530(4). The Third and the Fourth Specifications of professional misconduct are sustained.

4. Respondent is charged with committing professional misconduct under Education Law §6530(5) and §6530(6) by practicing the profession of medicine with incompetence on more than one occasion and by practicing the profession of medicine with gross incompetence.

Respondent provided counter-treatment (the opposite of proper treatment) to Patient A. Respondent demonstrated a complete lack of knowledge and competence as a psychiatrist in his treatment of a patient with Dissociative Identity Disorder (formerly Multiple Personality Disorder).

Respondent's repeated violation of professional boundaries, and repeated isolation of Patient A's child alters constitutes incompetence on more then one occasion.

Respondent's failure or refusal to recognize his entry into a physician-patient relationship shows a lack of the knowledge or skill required to practice the profession. Respondent's supervision of his wife; speaking personally to Patient A; sending gifts to and accepting gifts from Patient A; and allowing Patient A to become a house guest were some indications of Respondent's lack awareness of the proper requirements of his profession.

Respondent committed professional misconduct under Education Law §6530(5) and §6530(6). The Fifth and the Sixth Specifications of professional misconduct are sustained.

5. Respondent is charged with committing professional misconduct under Education Law §6530(32) by failing to maintain a record for a patient which accurately reflects the care and treatment of the patient.

Respondent did not maintain treatment notes or record the prescription of medication. Respondent failed to maintain a medical record for Patient A. Respondent committed professional misconduct under Education Law §6530(32). The Seventh Specification of professional misconduct is sustained.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law, Discussion, and Summary set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be Revoked.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including: (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) A fine not to exceed ten

thousand ($10,000.00) dollars on each specification of charges of which the respondent is determined to be guilty; (8) a course of education or training; (9) performance of up to five hundred (500) hours of public service; and (10) probation.

The Hearing Committee was less than impressed with Respondent's testimony. When questioned by the Hearing Committee, Respondent's responses seemed to convey a "this is the way it is" attitude. The Hearing Committee was left with an impression that Respondent came up with "a story" and "was going to stick to it" regardless of its believability. Respondent intervened and injected himself into patient care in spite of his denial to the contrary. It seemed that Respondent's action towards Patient A was predatory, or, at best, reckless. The Hearing Committee concluded that Respondent used and manipulated Patient A for his own gratification.

Furthermore, Respondent does not take the rules seriously. He failed to maintain appropriate boundaries with Patient A and even helped his wife cross those boundaries. When a physician writes a prescription he or she is practicing medicine and the physician has a duty and responsibility to take a history and physical and maintain a patient record.

Dr. Hopenwasser testified that she believed that a psychiatrist-patient relationship existed between Dr. Falcone and Patient A. She testified that a variety of factors support this conclusion. Most significant is the fact that once Dr. Falcone stepped in and managed or attempted to manage Patient A's clinical symptoms he established a psychiatrist-patient relationship. Dr. Hopenwasser went on to state that there was an intentional blurring of boundaries by both Ms. Burstein and Dr. Falcone. The delivery of drawings to Dr. Falcone by Ms Burstein, the exchange of toys, Dr. Falcone's telephone interactions with the child alters, his speaking to patient A about Ms. Burstein's mental deterioration, his soothing the alters who were terrified by the physical and mental loss of Ms Burstein and the writing of a prescription for Patient A were all factors establishing the psychiatrist-patient relationship. The Hearing Committee agrees with Dr. Hopenwasser's assessment.

Most significantly, once Dr. Falcone stepped in to manage patient A's clinical symptoms he created a clinical relationship with the patient irrespective of his intentions. It didn't matter when these interactions occurred either before the move to Florida or after. Telephone contact can be formal treatment, and extensive telephone contact to manage the symptoms or work with the alters constitutes formal psychiatric treatment. Dr. Hopenwasser also testified that once the interaction was established between Dr. Falcone and the alters, the interaction between Dr. Falcone and the alters were therapeutic interactions. The Hearing Committee agrees with Dr. Hopenwasser's assessment.

Since Respondent was not aware of the establishment of a physician-patient relationship, even after it was pointed out to him by] 2006), the Hearing Committee sees little hope that Respondent's conduct will change in the future. Respondent's misconduct cannot be corrected or remedied by a censure or a reprimand, by probation, by performance of public service, or by retraining. A temporary suspension, limitations on Respondent's license, or monitoring are all inappropriate sanctions in this matter. Rehabilitation or continued practice is only appropriate when a person has shown true remorse and wishes to atone. Respondent has not shown either.

The Hearing Committee considered allowing Respondent a limited practice in a facility under a supervised setting after a period of actual suspension, but saw this possibility as insufficient given all of the circumstances and facts in this proceeding, including the harm caused to the patient and the lack of recognition by Respondent.

Respondent made a colossal error in judgment. Despite Respondent's claim otherwise, the Hearing Committee has great doubt about Respondent's ability to treat patients.

According to Respondent's own testimony, his past female relationships have not been successful. Given the small amount of information that we have, we cannot conclude by a preponderance of the evidence, that he has established a predatory pattern of manipulation of other women. We only conclude that he was involved in a sexual relationship with one of his patients, Patient A.

Even the nature and testimony of Respondent's character witnesses were questionable. From Respondent, we saw no remorse, no humility, no sign that he understood the great harm that he caused despite his attempt to present a speech that was supposed to convince us otherwise.

The Hearing Committee believes that the penalty of license revocation should help protect the public, curb future unprofessional practice by Respondent, deter other licensees from similar temptations, and is in the interest of justice.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein. Specifically, Respondent's arguments are either rendered academic by the Hearing Committee's decision or have been found to be lacking in merit.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. All Factual Allegations (as discussed above) and Specification of Charges contained in the Statement of Charges (Department Exhibit # 1) are SUSTAINED; and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

3. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
September, 25, **2008**

Redacted Signature

PATRICK F. CARONE, M.D., M.P.H. (Chairperson)
DIANE M. SIXSMITH, M.D.
HENRY SIKORSKI, Ph.D.

Emanuel Falcone, M.D.
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APPENDIX 1

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

IN THE MATTER

OF

EMANUEL FALCONE, M.D.

STATEMENT

OF

CHARGES

EMANUEL FALCONE, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 22,1985, by the issuance of license number 163401 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From in or about 2003 through in or about 2006, Respondent engaged in the practice of medicine in his interactions with Patient A (identified in attached Appendix), a psychiatric patient. Respondent's failed to meet accepted standards of medical practice, in that:

1. During the year 2006, Respondent engaged in sexual contact with Patient A.
2. Throughout the period of 2003 through 2006, Respondent treated Patient A, a patient with Dissociative Identity Disorder, in an inappropriate manner.
3. Respondent failed to maintain a medical record for Patient A.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

SEXUAL CONTACT BY PSYCHIATRIST WITH PATIENT

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

1. Paragraph A and A 1.

SECOND SPECIFICATION

MORAL UNFITNESS

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

2. Paragraph A and A1, and or A2.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

3. Paragraph A and its subparagraphs.

FOURTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

4. Paragraph A and its subparagraphs.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

5. Paragraph A and its subparagraphs.

SIXTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. Paragraph A and its subparagraphs.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

7. Paragraph A and A3.

DATED: February 26, 2008
New York, New York

Redacted Signature

ROY EMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

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

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IN THE MATTER

OF

EMANUEL FALCONE, M.D.

ANSWER

----------X

EMANUEL FALCONE, M.D. ("Respondent"), by his attorneys Michael S. Kelton & Associates LLC, as and for his answer to the Statement of Charges dated February 26, 2008, states and alleges as follows:

1. Admits that Respondent was authorized to practice medicine in New York State on or about July 22, 1985 by the issuance of license number 163401 by the New York State Education Department.

FACTUAL ALLEGATIONS

2. Denies each and every allegation set forth at Factual Allegation A of the Statement of Charges, including, but not limited to, the allegations that Respondent engaged in the practice of medicine in his interactions with Patient A, and that Patient A was a psychiatric patient of Respondent's.

3. Admits each and every allegation set forth at Factual Allegation A.1.

4. Denies each and every allegation set forth at Factual Allegation A.2, and specifically denies that Respondent ever treated Patient A.

5. Admits each and every allegation set forth at Factual Allegation A.3.

Respondent 3-19-08 A Incvd.

SPECIFICATION OF CHARGES

6. Denies each and every allegation set forth at the First Specification alleging "Sexual Contact By Psychiatrist With Patient".

7. Denies each and every allegation set forth at the Second Specification alleging "Moral Unfitness".

8. Denies each and every allegation set forth at the Third Specification alleging "Negligence On More Than One Occasion".

9. Denies each and every allegation set forth at the Fourth Specification alleging "Gross Negligence".

10. Denies each and every allegation set forth at the Fifth Specification alleging "Incompetence On More Than One Occasion".

11. Denies each and every allegation set forth at the Sixth Specification alleging "Gross Incompetence".

12. Denies each and every allegation set forth at the Seventh Specification alleging "Failure To Maintain Records".

WHEREFORE, by reason of all of the foregoing, Respondent respectfully requests that the charges be dismissed in their entirety, together with such other and further relief as to this Hearing Committee seems just and proper.

Dated: New York, New York
March 12, 2008

Yours etc.
MICHAEL S. KELTON & ASSOCIATES LLC
Attorneys for Respondent
EMANUEL FALCONE, M.D.

By:_____
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