

FILED

September 11, 2008

**NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS**

ANNE MILGRAM
ATTORNEY GENERAL OF NEW JERSEY
Division of Law, 5th Floor
124 Halsey Street
P.O. Box 45029
Newark, NJ 07101
Attorney for the New Jersey State Board
of Medical Examiners

By: B. Michelle Albertson
Deputy Attorney General
Tel. (973) 648-2975

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF _____ :

STEPHEN M. SHAPIRO, M.D. :
License No. MA26983 :

TO PRACTICE MEDICINE AND SURGERY :
IN THE STATE OF NEW JERSEY :
_____ :

Administrative Action

CONSENT ORDER OF
VOLUNTARY SURRENDER
OF LICENSURE

THIS MATTER was opened to the New Jersey State Board of Medical Examiners ("Board") upon receipt of information that on or about March 21, 2008, the New York State Board for Professional Medical Conduct ("New York Board") entered a "Determination and Order" ("New York Order") revoking Respondent's New York license.

CERTIFIED TRUE COPY

More specifically, the New York Board sustained all charges contained in the First through Third, Sixth and Seventh Specifications, but dismissed the charges of the Fourth and Fifth Specifications. The New York Board determined that Respondent committed professional misconduct in violation of: (1) N.Y. Educ. Law §6530(44) by engaging in a long-standing sexual relationship with a patient; (2) N.Y. Educ. Law §6530(4) in that Respondent's conduct demonstrates an especially egregious departure from the standard of care, which constitutes gross negligence; (3) N.Y. Educ. Law §6530(3) in that Respondent's actions transpired on a number of occasions over a period of years, which demonstrates negligence on more than one occasion; (4) N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of medicine which evidenced moral unfitness to practice the profession; and (5) N.Y. Educ. Law §6530(32) by failing to maintain adequate medical records which adequately reflected the evaluation and treatment of Patients A and B.

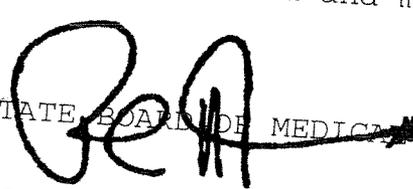
As a result of the foregoing, the Board has determined that the above New York disciplinary action taken against Respondent provides a basis for disciplinary action against Respondent's New Jersey license to practice medicine and surgery pursuant to N.J.S.A. 45:1-21(g).

IT NOW APPEARING that the parties wish to resolve this matter without recourse to formal proceedings and, accordingly, Respondent

now seeks leave to voluntarily surrender his license to practice medicine and surgery in the State of New Jersey to be deemed a revocation in accordance with the terms of this Order; and that the Respondent hereby waives any right to a hearing in this matter; and that Respondent's license was placed in an inactive status on June 30, 1995; and the Board finding the within Order adequately protects the public's health, safety and welfare; and for good cause shown;

IT IS ON THIS 5 day of August, 2008, ORDERED AND AGREED THAT:

1. Respondent shall immediately surrender his license to practice medicine and surgery in the State of New Jersey to be deemed a revocation of license with prejudice to reinstatement.
2. Respondent shall return his original New Jersey license to William Roeder, Executive Director, New Jersey State Board of Medical Examiners, P.O. Box 183, Trenton, New Jersey 08625-0183, contemporaneously with the signing of this Order.
3. Respondent shall abide by the Directives for Discipline/Surrender of Licenses attached and made a part hereto.


STATE BOARD OF MEDICAL EXAMINERS

By:

Paul C. Mendelowitz, M.D.
Board President

I have read and I understand
this Consent Order and agree to be
bound by its terms. I further
hereby consent to the entry of
this Consent Order.


STEPHEN M. SHAPIRO, M.D.

COPY

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

-----X
IN THE MATTER :
OF :
STEPHEN M. SHAPIRO, M.D. :
-----X

DETERMINATION
AND
ORDER

BPMC-08-43

A Notice of Hearing, dated August 13, 2007 and a Statement of Charges, dated August 11, 2007, were served upon the Respondent, Stephen M. Shapiro, M.D. **CHARLES J. VACANTI, M.D. (CHAIR), JAMES R. DICKSON, M.D., AND JANET M. MILLER, R.N.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10) (Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Joel E. Abelow, Esq., Associate Counsel. The Respondent appeared by Smith, Sovik, Kendrick & Sugnet, P.C., James D. Lantier, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service: August 21, 2007
Answer Filed: August 30, 2007
Pre-Hearing Conference: August 30, 2007
Hearing Dates: September 27, 2007
November 29, 2007
November 30, 2007
December 19, 2007
December 20, 2007
December 21, 2007
Witnesses for Petitioner: Patient A
Patient B
Richard B. Krueger, M.D.
[REDACTED]
Allan A. LaFlore
[REDACTED]
Witnesses for Respondent: Michael J. Lynch, M.D.
Stephen M. Shapiro, M.D.
Robert Tiso, M.D.
Ronald Kameny, M.D.
Deliberations Held: February 22, 2008¹

STATEMENT OF CASE

Petitioner has charged Respondent, a psychiatrist, with seven specifications of professional misconduct. The charges relate to Respondent's medical care and treatment of two patients (a husband and wife). The charges include allegations

¹ The Hearing Committee wishes to note that the substantial delays in the completion of this hearing were not due to any dilatory tactics on the part of either the Department or Respondent. They were caused by ongoing military service obligations imposed on the Department's counsel, and were unavoidable. In addition, the deliberations were twice re-scheduled due to inclement weather.

of physical contact of a sexual nature between a psychiatrist and patient, gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, moral unfitness, and failing to maintain accurate medical records. Respondent denied the allegations.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Stephen M. Shapiro, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 105678 on or about March 16, 1970. (Ex. #2).

2. Patient A [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
Patient B, [REDACTED]
[REDACTED]

Patient A's husband,

(T. 39-42).

3. Patient A's husband began to see Respondent in 1996 due to depression. Respondent diagnosed Patient B as having a bi-polar disorder, and began treating him with Depakote. Patient B felt that he had success in being treated by Respondent. (T. 178-179; Ex. #6, pp. 5-7).

4. Patient B felt that his wife, who also had a history of depression, might benefit from seeing Respondent. He therefore arranged for his wife to see Respondent. Patient A met with Respondent in a joint session with Patient B in March of 1997. (T. 183-184; Ex. #6, p. 7).

5. Generally, it is discouraged for a psychiatrist to treat a husband and a wife. There might be circumstances where it is appropriate (such as if there is only one provider in an area), but it is usually avoided because of the potential conflicts of interest. For example, if there is a divorce proceeding, where confidences on the part of a husband or wife would be part of a medical record, they would be potentially discoverable. (T. 370).

6. Respondent undertook to treat both Patient A and Patient B. In such a circumstance, he should have informed

the patients of the nature of the care, and the risks and benefits so that the physician can obtain their informed consent. That would imply an awareness of what the psychiatrist was doing and the presentation of alternative options. (T. 369-370).

7. At the March 1997 session, Respondent failed to mention joint treatment issues with the patients or to raise any concern about treating both of them. Respondent failed to document any such conversation and failed to obtain any informed consent to treat each patient while he was treating the other. (T. 45, 48, 194; Ex. #3, p. 2; Ex. #6, p. 7).

8. Both Patients A and B were treated by Respondent at his office in his home, on Fayetteville-Manlius Road. In Respondent's office, the desk sat in the corner and there were two couches, at a right angle. The office was attached to Respondent's house, though it had a separate entry. One could also access the house from the office, by going through the garage. (T. 45-48; Ex. E).

9. Starting approximately in March, 1997, both Patient A and Patient B were treated separately by Respondent. Both paid for these visits by check. Neither patient told Respondent that they were unable to afford treatment. (T. 55-56, 186-187).

10. Patient B continued treatment with Respondent until approximately May, 2000. At that time, the patient determined that his internist, a Dr. Blanchfield, could continue to address his treatment, and obtain the necessary blood tests. Patient B then terminated his treatment with Respondent. (T. 192-194).

11. Patient A saw Respondent almost weekly during the first year of treatment. During this time, Respondent tried a number of different therapies, including different medications. (Ex. #3, pp. 2-12).

12. Patient A had very positive feelings toward Respondent during the course of her treatment in 1997. As time went on, the conversations between them involved talking about feelings, about what was going on in her head. Respondent talked quite a bit about himself at the visits. Patient A began to be attracted to him because she thought he was very smart and very cultured. He seemed to know a lot about music and history. He spoke about his experiences in his life. (T. 57).

13. Patient A found herself being attracted to Respondent. She told her friend, [REDACTED] that she found herself attracted to her psychiatrist. (T. 58, 258-259).

14. Patient A's infatuation with Respondent was an example of "transference". Transference is the development or imposition of feelings and attitudes that one would have towards earlier childhood figures, on the treating psychiatrist. This is a well understood concept in the field of psychiatry. (T. 364).

15. Patient A told Respondent of her thoughts about him and her fantasies about him. She asked him if this was okay. Respondent indicated that transference does occur between a patient and physician and that is how it was left. (T. 59).

16. Sometime in October or November, 1997, Patient A indicated to Respondent that she was still having strong feelings towards him and did not know what that meant. She also indicated to him that she felt they had never really talked about what one does about that. Patient A was aware that Respondent was married. (T. 59-60).

17. Respondent noted in Patient A's medical record on November 4, 1997, "thoughts and fantasies about me. 'Is it okay?'". On January 20, 1998, Respondent described Patient A as "upset-agitated. Transference, attraction? Feels gyped. 'I want to start over'". (Ex. #3, pp. 8, 12).

18. A psychiatrist has a duty to manage transference that develops towards him, and to diminish the psychiatrist's own counter-transference that he would develop for the patient. (T. 361).

19. There are appropriate ways of handling transference. One way would be for the psychiatrist to ask the patient about the feelings. One could also obtain a consultation from another psychiatrist, or suggest referral to another psychiatrist if the feelings were so strong that they impaired treatment. (T. 364-365).

20. Respondent failed to appropriately deal with Patient A's developing transference. (T. 386-387, 392).

21. Patient A tried to become closer emotionally, and if possible, physically with Respondent. She bought heart candy around Valentine's Day of 1998, and selected candy that had words on it asking for a hug. In February, 1998, she left those hearts on Respondent's desk at the end of a session. He responded by hugging her. (T. 64).

22. After the hug, Patient A scheduled another appointment and put another heart candy on Respondent's desk for what she called a "rain check". The next morning, Patient A received a phone call from Respondent. He asked her "Are

you okay?" She said she was. Respondent indicated to her that he wanted to make sure. (T. 65).

23. At her next appointment, Patient A entered Respondent's office. He stood in front of her, took her hands and kissed Patient A with a passionate kiss. She described her emotions as "beside herself with joy". (T. 66).

24. Respondent told her that he had noticed her in the waiting room when she first starting coming to his office, because of her eyes. He told her that he was attracted to her, too. They kissed more than once. (T. 67).

25. Patient A had informed her friend, [REDACTED] of her feelings for Respondent. Ms. [REDACTED] "sarcastically" suggested that if Patient A wanted to make a gift of herself to Respondent, she should wrap herself in a ribbon underneath her clothes. (T. 261-262, 278-279).

26. Patient A had made another appointment with Respondent approximately within a week's time. She came to his office dressed, but underneath her clothes she wore a ribbon. After she arrived at his office, they went into the home and into the bedroom. They undressed and engaged in sexual intercourse. Respondent did not have difficulty having sex with her on that occasion. This was the first time Patient A had been into Respondent's home. (T. 68, 72-75).

27. Patient A described several specific things about Respondent's physical condition. He had a scar in the front from an appendectomy or some other surgery. He also had a scar on his back which he indicated was from back surgery. She noticed that Respondent's arms were thin, very white, and not muscular. She also noted that Respondent was [REDACTED] (T. 73-74).

28. In the beginning of their relationship, Patient A and Respondent had sexual relations fairly often. The patient was at his house many times for this purpose. Patient A had extensive knowledge about the interior of Respondent's house. She noted that to get into the master bedroom, one was required to walk into a large bathroom. (T. 69-71; Ex. E).

29. Once the sexual relationship began, Respondent stopped charging Patient A for her sessions. Previously, she had paid by check or cash, in the amount of approximately \$125 to \$150. She did not use her insurance because Respondent did not accept insurance. Thereafter, Respondent simply did not mention anything more to her about paying. (T. 50, 76-77).

30. Patient A continued to see Respondent professionally, in addition to romantically. He was still treating her, but they were not talking about it. If Patient A was not feeling great, Respondent would adjust her

medication. However, the visits were no longer on the couch. (T. 77).

31. The sexual relationship continued from February, 1998 through approximately July, 2005. Initially, Respondent and Patient A would meet one or two times a week, and have sexual intercourse or be intimate either in the Respondent's home, office, or at local hotels. These meetings were scheduled through telephone conversations, and Patient A was encouraged to page Respondent when she wanted to talk. (T. 78-81).

32. Respondent sometimes spoke to Patient A about his relationship with his wife, and they would also speak of how well Respondent and Patient A fit together. These comments led Patient A to believe that he did not want to be with his wife. This led Patient A to believe that maybe there was an opportunity for them to be together. (T. 83).

33. There were several occasions when Patient A and Respondent met at a church parking lot. They would then drive in a car together, and simply ride around. On one occasion, they took a ride to Oneida and went to a bar. On another occasion, they met in Chittenango, and drove to Verona Beach or the State Park, and brought a blanket out into the woods. They were sexually intimate in the woods. (T. 85-86).

34. On one occasion, they traveled to Philadelphia together. When they got to Philadelphia, they picked up Respondent's car. They then went to a hotel and had sexual intercourse. While driving back to Syracuse, they stopped along the way at a motel and had sex again. They returned home in the evening. (T. 88-89).

35. Respondent gave Patient A gifts, including a pair of earrings. The earrings were jade and had a triangular stone set in silver and gold. Respondent also gave her music, including five compact disc recordings of classical music. Patient A also gave Respondent gifts. (T. 95, 97-98; Ex. #9 and #10).

36. Patient A told two of her friends, [REDACTED] [REDACTED] about her relationship with Respondent. Ms. [REDACTED] lived in Syracuse. Patient A first told her about her relationship with Respondent shortly after Valentine's Day, 1998. (T. 232-233).

37. Ms. [REDACTED] would sometimes "cover" for Patient A when she was going to be with Respondent, in case Patient B called looking for her. This went on for several years. It included the occasion when Patient A traveled with Respondent to Philadelphia. (T. 234-235, 237-238).

38. Ms. [REDACTED] also learned about the relationship shortly after Valentine's Day. Patient A also told Ms. [REDACTED] about the gifts of earrings and classical music CDs which she received from Respondent. (T. 257-258, 264-265, 274).

39. After the first year or so of the relationship, the sexual contact became more intermittent. Still, it continued. During this time, Respondent was being treated for back pain. Occasionally, Respondent would not be able to engage in intercourse due to his back pain. On those occasions, they would be close physically. For example, Patient A would sit on Respondent's lap. Other times, Respondent mentioned that intercourse might be difficult due to pain medications he was taking, but he was still able to obtain an erection. (T. 101).

40. Patient A tried to end the relationship with Respondent on a number of occasions, but was unable to do so due to her feelings for him. She was attracted to Respondent and was reassured by him. Sometimes, the patient would call his office phone number just to hear his voice on the answering machine. Respondent told Patient A that he loved her every time they saw each other. (T. 100).

41. Patient A's relationship with her husband suffered during this time. In September, 1999, about a year and a half after the sexual relationship with Respondent began, she asked Patient B for a divorce. Respondent documented in his medical record for Patient B how poor the relationship was between Patient A and Patient B, once A began in treatment with Respondent. (Ex. #6).

42. The last time that Patient A had sexual intercourse with Respondent was in June of 2005. She went to his office. She wanted to end the relationship. Instead, they had sexual intercourse. After they had intercourse, she left, feeling dirty and used. Patient A never went to Respondent's office after June 2005. (T. 107-109).

43. After this meeting, Patient A did not see Respondent again, nor did she continue to call him. Nonetheless, Respondent called her. (T. 109-110).

44. On October 13, 2005, Respondent called Patient A on her cell phone. The date of the call was Yom Kippur, a date of emotional and religious significance for Patient A. This was a time of year when the patient was often emotionally vulnerable and Respondent knew this. Patient A did not return the call, but did preserve the message. (T. 109-113).

45. Respondent's message to Patient A, as recorded on the phone call was:

"Hi, [Patient A's first name], it's Steve. Umm, I couldn't not talk to you. I don't know how you feel about that. Ummm, this afternoon, after 2 I'll be free for a few hours, maybe you'd like a ahhhh, cup of coffee, and some conversation. If you don't, I certainly will understand, but, uhh, know that, uhh, I'm sitting in my office from 2:30 to 4:30 or 5 should you decide that it might be fun. Anyway, I'll talk to you, I hope, buh-bye." (Ex. #8).

46. When she received the phone message, Patient A felt sick. She felt like someone had punched her in the stomach, and she didn't know what to do. Patient A went to her friend, [REDACTED], told her what had happened, and let her listen to the message. (T. 111-113, 122-123).

47. Patient A then told her husband about the relationship with Respondent. She also told her brother, [REDACTED]. Patient A also wrote her brother a letter outlining what had occurred. (T. 115-117, 118-119; Ex. #16).

48. Medical records should be legible. The individual notes for each session should contain sufficient information such that the nature, purpose, goals, treatments instituted, and results would be evident. They should also contain descriptions of the patient's mental status. (T. 361-362).

49. It is a standard of care in the field of psychiatry to perform sequential mental status examinations. This is done each time the patient is seen and any changes are documented. This assists in forming the physician's impression and treatment plan. Information that goes into the mental status exam and evaluation include observations of the patient, how they are dressed and how they behaved. The psychiatrist should ask questions and comment or embody some description or quotation. This can be done on a more formal basis through a questionnaire such as the Beck Question Inventory. (T. 362-363).

50. The physician should also document some interim history, describing what the patient had done, whether he or she had taken medications, or various aspects of their behavior. (T. 363).

51. Respondent's medical records for Patient A lack detail and sequential mental status examinations. They offer no sense of a treatment plan. Respondent appeared to proceed through a number of steps of treatment for the patient's depression. However, he started and stopped various anti-depressants, and noted very brief summaries, but no detail as why medications were changed. (T. 362, 367-368).

52. Respondent's medical record for Patient A contains three references to the patient "terminating" treatment. This first occurred contemporaneously with the first sexual encounter, in February, 1998. Respondent's note for February 12, 1998, after nearly 50 visits over almost a year, is simply, "therapy terminated". (Ex. #3, p. 12).

53. The second "termination" note occurred without comment following the entry dated July 8, 1998. On February 3, 2000, Respondent noted "patient reappears". No other relevant information is set forth. (Ex. #3, pp. 14, 15).

54. The final "termination" note is dated April 26, 2000, where Respondent notes "for reasons unclear, patient called to terminate treatment". (Ex. #3, p. 15).

55. Respondent's termination notes do not adequately describe the circumstances of the purported "termination" of treatment of Patient A. The notes fail to describe why therapy has been terminated, where the patient has been referred, what the post termination treatment plan is, or whether the patient is improved. (T. 390-391).

56. Patient A began seeing Dr. Manring, another psychiatrist, shortly after she stopped seeing Respondent for her medications in the year 2000. At the first meeting, Patient A told him that she had had an affair with her

previous psychiatrist, although Patient A did not identify Respondent by name. Throughout her treatment with Dr. Manring, from mid 2000 to June 2005, Patient A continued to refer to her ongoing contact with Respondent - identified variously as her ex-psychiatrist, former psychiatrist, etc. (T. 102-104; Ex. #5, pp. 5, 15, 17, 30, 38, 55, 63).

57. Patient A identified Respondent as the former psychiatrist in her comment to Dr. Toni McCormack, beginning in October, 2005. (Ex. #4, pp. 4, 23, 25, 26, 29, 32).

CONCLUSIONS OF LAW

Respondent is charged with seven specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross

negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). A finding of gross

negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, supra, at 986; Minielly, supra, at 751.

Respondent has also been charged with engaging in conduct which evidences moral unfitness to practice the profession. To sustain an allegation of moral unfitness, the Department must show that Respondent committed acts which "evidence moral unfitness". There is a distinction between 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. The Committee is not called on to make an overall

judgment regarding a Respondent's moral character. 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.

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 by virtue of his licensure as a physician. Physicians have privileges that are available solely due to the fact that one is a physician. For instance, physicians have access to controlled substances and billing privileges that are available only to licensed physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Therefore, it is expected that a physician will not violate the trust the public has bestowed upon him or her by virtue of their professional status.

Second, moral unfitness can be seen as a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent. Miller v. Commissioner of Health, 270 A.D.2d 584, 703 N.Y.S.2d 830 (3rd Dept. 2000); Selkin v. State Board for Professional Medical Conduct, 279 A.D.2d 720, 719 N.Y.S.2d 195 (3rd Dept.)

appeal denied 96 N.Y.2d 928, 733 N.Y.S.2d 363 (2001); Barad v. State Board for Professional Medical Conduct, 282 A.D.2d 893, 724 N.Y.S.2d 488 (3rd Dept. 2001); Reddy v. State Board for Professional Medical Conduct, 259 A.D.2d 847, 686 N.Y.S.2d 520 (3rd Dept.) leave denied 93 N.Y.2d 813, 695 N.Y.S.2d 541 (1999).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented testimony from seven witnesses. Richard Krueger, M.D. presented expert testimony on behalf of the Department. Dr. Krueger is a board certified psychiatrist, with sub-specialty certifications in addiction psychiatry and forensic psychiatry. He has over 30 years experience in the practice of medicine. Dr. Krueger's testimony was unbiased, understandable and addressed the central issues in the case. The Committee found him to be a credible witness.

The Department also presented testimony by [REDACTED]. Both women are personal friends of Patient A. Their testimony demonstrated that Patient A told

both of them about her relationship with Respondent, as it was unfolding. The Committee found them both to be credible witnesses.

Allan LaFlore, an investigator for the Office of Professional Medical Conduct, testified as to the nature of his investigation into the patient's complaint. The Committee found him to be a generally credible witness. [REDACTED] Patient A's brother, also testified. The Committee found him to be credible. However, his testimony was not particularly useful in our deliberations.

Patients A and B also testified for the Department. The Committee evaluated their testimony with great care. We find both of them to be credible witnesses. Both suffer from significant psychiatric disorders, yet their testimony was clear, coherent and unshakeable. In particular, Patient A was able to testify in great detail, regarding matters such as the layout of Respondent's bedroom, as well as significant anatomical characteristics of his body. Respondent conceded that her testimony regarding his home and his surgical scars was accurate. Both [REDACTED] and [REDACTED] confirmed that Patient A confided in them about her involvement with Respondent, as it was unfolding. The Committee placed great weight on Patient A's testimony.

Respondent presented three witnesses, and testified on his own behalf. Michael Lynch, M.D. is a very well-qualified forensic psychiatrist. Dr. Lynch agreed with Dr. Krueger that Respondent's medical records were inadequate. (T. 464-466). However, his main point of contention was his opinion that Patient A's claims were likely just a fantasy. (T. 454-455).

Dr. Lynch rendered this opinion without examining the patient, and in the absence of any evidence in any of her treatment records which might support his opinion. Moreover, his opinion did not account for the fact that Patient A had detailed knowledge of Respondent's home and his anatomy, or the fact that the patient had made contemporaneous comments about the relationship to her friends. He also could not account for Respondent's October, 2005 phone call to Respondent. Dr. Lynch had to acknowledge that this call was at best "perplexing". (T. 444-445). Consequently, the Hearing Committee placed less weight on Dr. Lynch's testimony than that of Dr. Krueger.

Respondent also presented Ronald Kameny, M.D., and Robert Tiso, M.D. Dr. Kameny is a long-time friend of Respondent, and was his primary care physician for many years. Dr. Tiso is a pain management specialist who is treating Respondent for chronic pain. Both gave straightforward, credible testimony. However, their testimony did not help

Respondent. To the contrary, their testimony demonstrated the fallacy of Respondent's claimed defense.

Both doctors' records indicate that there were periods of time when Respondent's back pain was well-controlled. In addition, there were no records to support Respondent's claims of severe, debilitating pain during the period of early 1998 to early 1999 (the period of greatest sexual activity by Respondent and Patient A). (See, Ex. #11 and #13). Most importantly, Dr. Kameny was unaware that Respondent had claimed that Kameny had prescribed Viagra for Respondent on three occasions during 2001-2002. (T. 672-674). Dr. Kameny denied ever prescribing Viagra for Respondent. (T. 744-745).

Lastly, Respondent testified in his own behalf. He obviously has an intense interest in the outcome of this proceeding, and the Hearing Committee evaluated his testimony accordingly. For the reasons set forth below, we find that Respondent was not a credible witness.

Truthfulness is an essential component of credibility. The evidence amply established that Respondent lied, while under oath, to this Hearing Committee. Respondent claimed that he could not have sexual relations with Patient A, because he was physically unable to perform. As part of this defense, he testified that Dr. Kameny had prescribed Viagra for him on three

occasions during 2001 - 2002, without success. (T. 672-674).

This was a lie.

The Department produced pharmacy records demonstrating that Respondent prescribed Viagra for himself - not once or twice, but twelve times (a total of 96 doses) - during the years 2000-2003. (Ex. #21). Dr. Kameny denied ever prescribing Viagra for Respondent, and there is nothing in his medical record for Respondent to support such a claim. (T. 744-745; Ex. #11).

Thus, Respondent lied - first, as to who prescribed the Viagra, and second, as to the frequency. Such frequent use of Viagra is completely inconsistent with a claim of a total inability to engage in sexual intercourse. For this reason alone, we could conclude that Respondent was not a credible witness. However, there other instances which demonstrate his complete lack of credibility.

Respondent admitted that Patient A had intimate knowledge of both his home and his body. He claimed that he found the patient in his home without permission. (T. 582-583). He also claimed that he discussed his surgical scars from his October, 2000 surgery with Patient A after a visit following the surgery. (T. 629-630). However, Patient A's medical record documents her last visit occurring in April, 2000. (Ex. #3, p.

15). This was months **before** the surgery was even scheduled.
(Ex. #14, p. 20).

Respondent provided no rational explanation for discussing such intimate subjects as his surgical scars with a psychiatric patient, let alone discussing them some eight months before the surgery was even performed. The Committee considers it far more likely that the Patient's knowledge of the Respondent's home and anatomy came from repeated visits to the home for the purposes of engaging in sexual intercourse.

Lastly, Respondent's explanation for his October 13, 2005 phone message left on Patient A's cell phone defies believability. Respondent claimed that, after years of not treating Patient A, he happened to read some medical literature in October, 2005 that he thought was relevant to her. He then called the patient, on her cell phone and left a message that did not mention anything about medical literature. What Respondent **did** say was:

Hi, [Patient A's first name], it's Steve. Um, I couldn't not talk to you. I don't know how you feel about that. Um, this afternoon, after two I'll be free for a few hours, maybe you'd like a, uh, cup of coffee, and some conversation. If you don't, I certainly will understand, but, uh, know that uh, I'm sitting in my office from two-thirty to four-thirty or five, should you decide that it might be fun. Anyway, I'll talk to you, I hope, buh-bye. (Ex. #7A; Ex. #8).

This message is intimate, familiar, and totally unprofessional. It is completely consistent with a call to a close and possibly intimate friend, and completely inconsistent with an attempt by a psychiatrist to share medical information with a former patient.

The record is replete with other instances where Respondent's testimony is at complete odds with the documented evidence. Based on the above-mentioned examples, and the record as a whole, the Hearing Committee determined that Respondent was not a credible and trustworthy witness.

Patient A

Patient A first began treatment with Respondent in March, 1997. She was suffering from a major depressive disorder. In addition, she was experiencing ongoing tension in her marriage to Patient B. This left her particularly vulnerable. Respondent was already treating Patient B at the time that Patient A began seeing him. Due to the potential for conflicts of interest, it is generally not advisable to treat both spouses. However, if one is going to proceed with treatment, it is essential to obtain and document informed consent from both patients. Respondent failed to do this.

Over time, Patient A began to develop emotional feelings for Respondent. This is known as transference, and is

a recognized concept in the field of psychiatry. Respondent had an obligation to appropriately manage this transference, as well as any counter-transference which he might develop towards the patient.

Respondent was well aware that any sexual relations with a psychiatric patient is wrong. (T. 633). Nevertheless, instead of properly managing the patient's emotional feelings toward him, he embarked on a lengthy emotional and sexual relationship with the patient. Even though Patient A sought to break off the relationship several times over the years, Respondent used his knowledge of her vulnerabilities to manipulate her into returning. His last attempt to bring Patient A back to him was preserved in the October 13, 2005 voice mail message.

During the entire time that Respondent was providing treatment for Patient A, he failed to appropriately and adequately document the treatment in the medical record. Both Dr. Krueger and Dr. Lynch agreed that Respondent's records were of poor quality. Based on the foregoing, the Hearing Committee sustained Factual Allegations A, and A.1 through A.9, and A. 11 (A.5 by a 2-1 vote). The Committee did not sustain Factual Allegation A.10, as Patient B testified that he voluntarily terminated treatment with Respondent.

Patient B

As noted previously, Patient B was the first of the couple to see Respondent. He ultimately recommended that his wife also see Respondent. Our findings regarding the lack of informed consent for treatment of both spouses are equally applicable to Patient B. Accordingly, the Hearing Committee sustained Factual Allegations B and B.2. The Committee concluded that there was insufficient evidence to sustain Factual Allegation B.1.

Specifications

The preponderance of the evidence demonstrated that Respondent engaged in a long-standing sexual relationship with Patient A. N.Y. Education Law §6530(44) expressly prohibits any physical contact of a sexual nature between a psychiatrist and patient (with certain exceptions not relevant here). Accordingly, the Committee voted to sustain the First Specification.

Respondent was well aware that a sexual relationship with Patient A was prohibited. Nevertheless, he entered into the relationship and manipulated the patient's vulnerabilities to prolong it. He failed to obtain informed consent, maintain adequate medical records, and appropriately manage the patient's transference of feelings towards him. The Hearing Committee

unanimously concluded that Respondent's conduct demonstrated an especially egregious departure from the standard of care, and thus constituted a violation of N.Y. Education Law §6530(4) [Gross Negligence]. Therefore, the Hearing Committee voted to sustain the second Specification. Insofar as the Respondent's actions transpired on a number of occasions over a period of years, the Committee also determined that Respondent's conduct demonstrated negligence on more than one occasion, in violation of N.Y. Education Law §6530(3). Accordingly, the Committee voted to sustain the Third Specification.

The Fourth and Fifth Specifications allege that Respondent demonstrated gross incompetence (N.Y. Education Law §6530(6)) and incompetence on more than one occasion (N.Y. Education Law §6530(5)). The Hearing Committee found no evidence to conclude that Respondent lacked the skill or knowledge necessary to practice. On the contrary, the Committee concluded that Respondent ignored basic tenets of good practice in his conduct towards Patients A and B. As a result, the Committee voted to dismiss the Fourth and Fifth Specifications.

The Sixth Specification alleged that Respondent engaged in conduct in the practice of medicine which evidenced moral unfitness to practice the profession, in violation of N.Y. Education Law §6530(20). The evidence in support of this

specification is compelling. Respondent, a psychiatrist, embarked on a lengthy sexual and emotional relationship with Patient A, a woman suffering from a major depressive disorder. He exploited her feelings and vulnerabilities for his own gratification. Respondent's conduct demonstrated an extreme breach of the public trust and a violation of the moral and ethical standards of the medical profession. Therefore, the Hearing Committee sustained the Sixth Specification.

The Seventh Specification alleged that Respondent failed to maintain records which adequately reflected the evaluation and treatment of both Patients A and B, in violation of N.Y. Education Law §6530(32). As was noted earlier, both Dr. Krueger and Dr. Lynch agreed that Respondent's medical records were inadequate. There was insufficient documentation of Respondent's medication decisions, responses to medication, and details of psychotherapy. In addition, he failed to document informed consent to treatment by both patients. Accordingly, the Hearing Committee voted to sustain the Seventh Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence in this case demonstrated that Respondent engaged in an inappropriate sexual and social relationship with Patient A over a period of many years. He was well aware that Patient A was an extremely troubled and vulnerable woman, suffering from a major depressive disorder. Rather than maintain a sense of professional detachment, Respondent took advantage of the patient for his own gratification.

This was not an isolated instance of bad behavior, but a long-standing pattern of manipulation on Respondent's part. Patient A was desperately trying to end the relationship. However, Respondent's October 13, 2005 phone call made it clear that he was trying to draw her back.

Respondent's actions not only put Patient A's well being at risk, but also that of her husband, Patient B. Since

Respondent was treating them both, he exploited the difficulties in their relationship for his own benefit. Respondent's conduct represents an especially egregious violation of the public trust, and a gross abuse of the powers and privileges granted to members of the medical profession.

Many instances of poor care were essentially not disputed by the experts. Respondent's lack of necessary documentation, his concurrent treatment of husband and wife, and his failure to appropriately address Patient A's transference issues, were criticized by both Dr. Krueger and Dr. Lynch. Nevertheless, when asked what he had learned from this case, all he said was to "keep better records...that's about it". (T. 685).

Lastly, the Committee notes that Respondent blatantly lied under oath. Moreover, he attempted to draw his own treating physician (Dr. Kameny) into his web of deceit. By testifying falsely in this proceeding, Respondent again violated his trust, with the public and with this Hearing Committee. It is thus clear that he cannot be entrusted with the care of society's most troubled and vulnerable members. Each of the sustained charges warrant revocation. Taken as a whole, revocation is the only sanction which will protect the public from future predation by this physician.

ORDER

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

1. The First through Third, Sixth and Seventh Specifications of professional misconduct, as set forth in the Statement of Charges, (Exhibit #1) are SUSTAINED;

2. The Fourth and Fifth Specifications of professional misconduct, as set forth in the Statement of Charges are DISMISSED;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is REVOKED;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

^{PITTSFORD}
DATED: ^{Troy,} New York
21 MARCH, 2008

Signature Redacted

CHARLES J. VACANTI, M.D. (CHAIR)

JAMES R. DICKSON, M.D.
JANET M. MILLER, R.N.

TO: Michael A. Hiser, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2512
Empire State Plaza
Albany, New York 12237

Stephen M. Shapiro, M.D.
Address Redacted

James D. Lantier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street - Suite 600
Syracuse, New York 13202-1252

APPENDIX I

IN THE MATTER

OF

STEPHEN MICHAEL SHAPIRO, M.D.

STATEMENT
OF
CHARGES

STEPHEN MICHAEL SHAPIRO, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 16, 1970, by the issuance of license number 105678 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A from 1997 through 2000, at his office at 900 Manlius Street, Fayetteville, New York 13066.

Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Respondent began treating Patient A in 1997 for depression at the urging of her husband, Patient B, who was also a patient of Respondent.
2. On or about Valentine's day, 1998, during an office session, Patient A gave Respondent a Valentine candy on which was written, "hug me". Respondent came from behind his desk and gave Patient A a hug. On a subsequent visit approximately one week later, Respondent greeted Patient A with an embrace and a kiss on the lips and told her he had always admired her eyes. A week later after a session, Respondent took Patient A upstairs to his bedroom and they had sexual intercourse.

3. Respondent and Patient A continued to have sexual intercourse approximately three times per week, at Respondent's office, in Respondent's bedroom, and at various motels.
4. During this sexual affair, Respondent continued to see Patient A as a patient and prescribe her medication; however, Respondent discontinued charging Patient A for visits.
5. The frequency of the sexual encounters gradually decreased to approximately once a month, and continued through June 2005. Patient A had terminated her relationship as Respondent's patient in 2000.
6. Respondent mismanaged Patient A's transference and his own counter-transference to Patient A.
7. Respondent failed to adequately treat and document his treatment of Patient A.
8. Respondent's medical records for Patient A are of poor legibility. They lack detail and they lack sequential mental status examinations. They offer no ongoing sense of what the treatment plan was.
9. Respondent failed to obtain and document informed consent from Patient A, regarding his simultaneous treatment of Patient A and Patient B.
10. During the affair and during sessions, Respondent used to "bad mouth" Patient B to Patient A, and eventually discharged Patient B from his care.
11. Respondent failed to document medication decisions, responses to medications, details of psychotherapy, or collateral progress information from relatives, to treat Patient A for

depression.

B. Respondent provided medical care to Patient B from August 1996 through July 2000, at his office at 900 Manlius Street, Fayetteville, New York 13066. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Respondent's sexual misconduct with Patient A placed Patient B at risk, including causing him to distrust care-givers, exposing him to the risk of sexually transmitted diseases, and creating distrust towards his wife because of her infidelity.
2. Respondent's failure to obtain and document informed consent from Patient B placed the mental health of Patient B at great risk, by failing to explain to Patient B the potential for a conflict of interest between Patient A's interests and Patient B's interests.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

IN THE PRACTICE OF PSYCHIATRY, ANY PHYSICAL CONTACT OF A SEXUAL NATURE BETWEEN LICENSEE AND PATIENT

Respondent is charged with being In The Practice of Psychiatry, and Having Physical Contact of a Sexual Nature Between Licensee and Patient A, in violation of N.Y. Education Law Section 6530(44), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5.

SECOND SPECIFICATION
PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with Practicing the Profession with Gross Negligence on a Particular Occasion, in violation of N.Y. Education Law Section 6530(4), in that Petitioner Charges the Following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6.

THIRD SPECIFICATION
PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Negligence on More Than One Occasion, in violation of New York Education Law Section 6530(3), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.9, A and A.10, B and B.1, B and B.2.

FOURTH SPECIFICATION
PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with Practicing the Profession with Gross Incompetence, in violation of N.Y. Education Law Section 6530(6), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, B and B.1.

FIFTH SPECIFICATION
PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Incompetence on More Than One Occasion, in violation of N.Y. Education Law Section 6530(5), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, B and B.1, B and B.2.

SIXTH SPECIFICATION
CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

Respondent is charged with Conduct in the Practice of Medicine Which

Evidences Moral Unfitness to Practice Medicine, in violation of N.Y. Education Law Section 6530(20), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4; A and A.5, A and A.6, A and A.7, B and B.1, B and B.2.

SEVENTH SPECIFICATION
FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH
ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE
PATIENT

Respondent is charged with Failing to Maintain a Record for Each Patient Which Accurately Reflects the Evaluation and Treatment of the Patient, in violation of N.Y. Education Law Section 6530(32), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.7, A and A.8, A and A.11, B and B.2.

DATE: August //, 2007
Albany, New York

Signature Redacted
Peter D. VanBuren
Deputy Counsel
Bureau of Professional Medical Conduct

**DIRECTIVES APPLICABLE TO ANY MEDICAL BOARD LICENSEE
WHO IS DISCIPLINED OR WHOSE SURRENDER OF LICENSURE
HAS BEEN ACCEPTED**

APPROVED BY THE BOARD ON MAY 10, 2000

All licensees who are the subject of a disciplinary order of the Board are required to provide the information required on the Addendum to these Directives. The information provided will be maintained separately and will not be part of the public document filed with the Board. Failure to provide the information required may result in further disciplinary action for failing to cooperate with the Board, as required by N.J.A.C. 13:45C-1 et seq. Paragraphs 1 through 4 below shall apply when a license is suspended or revoked or permanently surrendered, with or without prejudice. Paragraph 5 applies to licensees who are the subject of an order which, while permitting continued practice, contains a probation or monitoring requirement.

1. Document Return and Agency Notification

The licensee shall promptly forward to the Board office at Post Office Box 183, 140 East Front Street, 2nd floor, Trenton, New Jersey 08625-0183, the original license, current biennial registration and, if applicable, the original CDS registration. In addition, if the licensee holds a Drug Enforcement Agency (DEA) registration, he or she shall promptly advise the DEA of the licensure action. (With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board. In addition, at the conclusion of the term, the licensee should contact the DEA to advise of the resumption of practice and to ascertain the impact of that change upon his/her DEA registration.)

2. Practice Cessation

The licensee shall cease and desist from engaging in the practice of medicine in this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an opinion as to professional practice or its application, or representing him/herself as being eligible to practice. (Although the licensee need not affirmatively advise patients or others of the revocation, suspension or surrender, the licensee must truthfully disclose his/her licensure status in response to inquiry.) The disciplined licensee is also prohibited from occupying, sharing or using office space in which another licensee provides health care services. The disciplined licensee may contract for, accept payment from another licensee for or rent at fair market value office premises and/or equipment. In no case may the disciplined licensee authorize, allow or condone the use of his/her provider number by any health care practice or any other licensee or health care provider. (In situations where the licensee has been suspended for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is suspended, for the payment of salaries for office staff employed at the time of the Board action.)

A licensee whose license has been revoked, suspended for one (1) year or more or permanently surrendered must remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from professional listings, telephone directories, professional stationery, or billings. If the licensee's name is utilized in a group practice title, it shall be deleted. Prescription pads bearing the licensee's name shall be destroyed. A destruction report form obtained from the Office of Drug Control (973-504-6558) must be filed. If no other licensee is providing services at the location, all medications must be removed and returned to the manufacturer, if possible, destroyed or safeguarded. (In situations where a license has been suspended for less than one year, prescription pads and medications need not be destroyed but must be secured in a locked place for safekeeping.)

3. Practice Income Prohibitions/Divestiture of Equity Interest in Professional Service Corporations and Limited Liability Companies

A licensee shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice. The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board action.

A licensee who is a shareholder in a professional service corporation organized to engage in the professional practice, whose license is revoked, surrendered or suspended for a term of one (1) year or more shall be deemed to be disqualified from the practice within the meaning of the Professional Service Corporation Act. (N.J.S.A. 14A:17-11). A disqualified licensee shall divest him/herself of all financial interest in the professional service corporation pursuant to N.J.S.A. 14A:17-13(c). A licensee who is a member of a limited liability company organized pursuant to N.J.S.A. 42:1-44, shall divest him/herself of all financial interest. Such divestiture shall occur within 90 days following the the entry of the Order rendering the licensee disqualified to participate in the applicable form of ownership. Upon divestiture, a licensee shall forward to the Board a copy of documentation forwarded to the Secretary of State, Commercial Reporting Division, demonstrating that the interest has been terminated. If the licensee is the sole shareholder in a professional service corporation, the corporation must be dissolved within 90 days of the licensee's disqualification.

4. Medical Records

If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shall ensure that during the three (3) month period following the effective date of the disciplinary order, a message will be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month for three (3) months in a newspaper of

general circulation in the geographic vicinity in which the practice was conducted. At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to medical records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her medical record or asks that record be forwarded to another health care provider, the licensee shall promptly provide the record without charge to the patient.

5. Probation/Monitoring Conditions

With respect to any licensee who is the subject of any Order imposing a probation or monitoring requirement or a stay of an active suspension, in whole or in part, which is conditioned upon compliance with a probation or monitoring requirement, the licensee shall fully cooperate with the Board and its designated representatives, including the Enforcement Bureau of the Division of Consumer Affairs, in ongoing monitoring of the licensee's status and practice. Such monitoring shall be at the expense of the disciplined practitioner.

(a) Monitoring of practice conditions may include, but is not limited to, inspection of the professional premises and equipment, and inspection and copying of patient records (confidentiality of patient identity shall be protected by the Board) to verify compliance with the Board Order and accepted standards of practice.

(b) Monitoring of status conditions for an impaired practitioner may include, but is not limited to, practitioner cooperation in providing releases permitting unrestricted access to records and other information to the extent permitted by law from any treatment facility, other treating practitioner, support group or other individual/facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained by a rehabilitation program for impaired practitioners. If bodily substance monitoring has been ordered, the practitioner shall fully cooperate by responding to a demand for breath, blood, urine or other sample in a timely manner and providing the designated sample.

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.