



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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

Patrick F. Carone, M.D., M.P.H.
Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

October 22, 1998

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Robert Rockwell, M.D.
8 Thurlow Terrace
Albany, New York 12203

RE: License No. 124630

Dear Dr. Rockwell:

Enclosed please find Order #BPMC 98-248 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **October 22, 1998**.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Dennis A. First, Esq.
O'Connor, O'Connor, Mayberger & First
20 Corporate Woods Boulevard
Albany, New York 12211

Valerie B. Donovan, Esq.

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

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IN THE MATTER : SURRENDER
OF : ORDER
ROBERT ROCKWELL, M.D. : BPMC # 98-248
: :
-----X

ROBERT ROCKWELL, M.D., says:

On or about July 22, 1975, I was licensed to practice medicine as a physician in the State of New York having been issued License No. 124630 by the New York State Education Department.

I understand that I have been charged with specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for an agreement to allow me to surrender my license as a physician in the state of New York and request that the Board issue this Surrender Order.

I admit guilt to the First Specification concerning Patients C, D, E, F, G, H and I as set forth in the Statement of Charges in full satisfaction of the charges against me.

I understand that, in the event that this proposed agreement

is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such proposed agreement shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that in the event the state board for Professional Medical Conduct agrees with my proposal, this Order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me. I agree that this Order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Order to me at the address set forth above, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this agreement of my own free will and accord and not under duress, compulsion, or restraint of any kind or manner.


ROBERT ROCKWELL, M.D.
Respondent

AGREED TO:

Date: 10/16, 1998


DENNIS A. FIRST, Esq.
Attorney for Respondent

Date: 10/20, 1998


VALERIE B. DONOVAN
Assistant Counsel
Bureau of Professional
Medical Conduct

Date: 10/20, 1998


ANNE P. SAILER
Director, Office of
Professional Medical Conduct

NYS DOH/BPMC

Fax:518-473-2430

ORDER

The undersigned has received the proposed Surrender Agreement of Robert Rockwell, M.D.. It appears that the Office of Professional Medical Conduct (OPMC) has conducted an investigation of the incidents giving rise to this Agreement, including interviewing witnesses, the Respondent, reviewing pharmaceutical and hospital records, and retaining an expert to review the entire case. OPMC has concluded that there is evidence to prove the matters alleged in the Statement of Charges, warranting disciplinary action. It appears that this Order is in the public interest because it expeditiously resolves this matter and avoids requiring psychiatric patients to go through the stress of participating at a hearing. Furthermore, this Surrender Order immediately removes Respondent from practice as a physician.

Accordingly, upon the proposed agreement of ROBERT ROCKWELL, M.D., to Surrender his license as a physician in the State of New York, which proposed agreement is made a part hereof, it is AGREED TO and

ORDERED, that the proposed agreement and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this Order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of this Order to Respondent at the address set forth in this agreement or to Respondent's attorney, or upon transmissions via facsimile to Respondent or Respondent's

attorney, whichever is earliest.

DATED: 10/21/98

Patrick F. Carone, M.D.

PATRICK F. CARONE, M.D., M.P.H.
Chair
State Board for Professional
Medical Conduct

2. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of patient A when Respondent began treating Patient A.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient A.
4. Respondent violated appropriate and therapeutic professional boundaries with Patient A by engaging in behavior including but not limited to the following:
 - a. Respondent, from in or about February, 1996 through in or about April, 1998, engaged in physical contact of a sexual nature with Patient A including frequent occasions of sexual intercourse at his home, at hotel rooms while attending professional conferences, and at the homes of his relatives.
 - b. Respondent, from in or about the summer of 1996 through in or about March 1998, developed a social relationship with Patient A and her family: Respondent frequently dined at the home of Patient A and her husband, Patient A and her husband frequently had dinner at Respondent's house, and/or Respondent spent holidays with Patient A and her family.
 - c. Respondent, without Patient A's permission, disclosed personally identifiable information regarding Patient A to Respondent's family and colleagues.
 - d. Respondent divulged personally identifiable information regarding his other patients to Patient A.
 - e. Respondent divulged personal information about himself that was not pertinent to therapy for Patient A on numerous occasions, including information regarding Respondent's own marital difficulties and sexual practices;
 - f. Respondent gave Patient A and her husband mobile phones and paid for the accounts and bills;
 - g. Respondent repeatedly telephoned Patient A, sometimes requesting to speak with a specific one of her multiple personalities (alters), at her home, often three times per day, including late evening calls lasting one to two hours;
 - h. Respondent, in or about April, 1997, without Patient A's permission, disclosed personally

identifiable information about Patient A's history to two of Patient A's sisters;

- i. Respondent gave Patient A gifts including sandals and a home computer;
- j. Respondent, in or about May, 1998, sent a note to Patient A addressed to one of Patient A's alters, and enclosed a copy of the summary of her treatment that he had previously sent to the Office of Professional Medical Conduct.
5. Respondent, while Patient A was a patient at St. Peter's Hospital, Albany, New York, wrote and filled a prescription for Xanax for Patient A. Respondent was not on the staff of the hospital, did not have privileges at this hospital, and was not her physician of record,
6. Respondent, while Patient A was a patient at Albany Medical Center, Albany, New York, for evaluation for abdominal pain, wrote a prescription for, and gave her Xanax. Respondent was not on the staff of the hospital.
7. Respondent, in or about September, 1997, while Patient A was hospitalized at Four Winds, Saratoga, New York, interfered with the treatment being given by the hospital staff to Patient A by meeting with Patient A on a daily basis in her bedroom, by interacting inappropriately with Four Winds hospital staff and by criticizing Four Winds staff to Patient A.

B. Respondent treated Patient B, a female patient born July 11, 1951, for Dissociative Identity Disorder, from on or about January, 1994 through on or about May, 1996, at Respondent's Office. Respondent's care and treatment of Patient B failed to meet acceptable standards of care in that:

1. Respondent, in or about the fall of 1994 had Patient B participate in a symposium sponsored by Respondent in which she spoke as a survivor of satanic ritual abuse.
2. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient B.
3. Respondent violated appropriate and therapeutic professional boundaries with Patient B, in that:

- a. Respondent, from on or about October, 1994, through on or about February 1995 had Patient B work in his office in return for a reduction in therapy session fees.
 - b. Respondent had Patient B work as secretary of his organization, the Friends of Jung, on an unpaid basis for approximately eighteen months.
 - c. Respondent, on or about 1995, while Patient B was undergoing therapy with Respondent, socialized and had dinner with Patient B and her husband.
 - d. Respondent, responding to Patient B's request for her records, gave Patient B other patients' records.
 - e. Respondent accepted approximately \$800 as a gift from Patient B and other patients at a birthday party held for Respondent.
 - f. Respondent disclosed personally identifiable information regarding other patients to Patient B.
 - g. Respondent used Patient B's art work without her permission at various symposia.
 - h. Respondent had Patient B retype symposium transcripts without paying her for 200 hours of work.
 - i. Respondent disclosed to Patient B confidential information regarding his personal sex life and marital relationships.
 - j. Respondent, on or about May 2, 1996, appeared at Albany Memorial Hospital while Patient B was being treated for back pain and brought her work to complete for his organization, the Friends of Jung.
 - k. Respondent accepted approximately \$3,000 from Patient B and her husband in order to complete work for the Friends of Jung.
4. Respondent, while Patient B was a patient at Albany Memorial Hospital, disclosed information about Patient B to hospital staff without Patient B's permission.
 5. Respondent, while Patient B was a patient at Albany Memorial Hospital, without permission of Patient B, or without request by the attending physician, fraudulently signed into the hospital as a "consult" and fraudulently billed Patient B's insurance company for this visit.

6. Respondent failed to appropriately treat Patient A's Dissociative Identity Disorder.

C. Respondent provided psychiatric care to Patient C in or about April, 1995, immediately following a suicide attempt by Patient C. Patient C presented with a history of bipolar disorder, anxiety and alcoholism. Respondent's care and treatment of Patient C failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of patient C when Respondent began treating Patient C.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient C during the course of treatment.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient C.
4. Respondent prescribed medications to Patient C without contacting her physician or clinic and prescribed them in inappropriate amounts.

D. Respondent provided psychiatric care to Patient D, who presented for treatment of agoraphobia, from on or about February, 1989 through on or about July, 1997. Respondent's care and treatment of Patient D failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of Patient D when Respondent began treating Patient D.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient D during the course of her treatment.
3. Respondent failed to maintain a record which adequately

reflects the care, treatment and evaluation of Patient D.

4. Respondent treated and prescribed for Patient D for several months based only on telephone contacts without meeting the patient in person.

E. Respondent provided psychiatric care to Patient E, a female born April 14, 1930, presenting with adjustment disorder, anxiety and depression, from on or about March 25, 1988 through on or about January 24, 1997 at Respondent's office. Respondent's care and treatment of Patient E failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of Patient E when Respondent began treating Patient E.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient E during the course of treatment.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient E.
4. Respondent prescribed medication to Patient E inappropriately and/or in inappropriate amounts without adequate in-person office visits.

F. Respondent provided medical care to Patient F, a female born September 27, 1913, presenting with senile dementia with delusional features, from on or about October 12, 1988 through on or about June, 1997 at his office. Respondent's care and treatment of Patient F failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of Patient F when Respondent began treating

Patient F.

2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient F during the course of treatment.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient F.
4. Respondent prescribed medications to Patient F without adequate indication.

G. Respondent provided medical care to Patient G, a female born on October 6, 1945, from on or about December 23, 1994, through on or about January 15, 1997. Respondent's care and treatment of patient G failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or document an adequate history and/or mental status evaluation of Patient G when Respondent began treating Patient G.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient G during the course of treatment.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient G.
4. Respondent inappropriately prescribed medication to Patient G while knowing Patient G was a substance abuser.

H. Respondent provided medical care to Patient H, a male born on March 7, 1939, presenting with anxiety and panic attacks, from in or about March 1990 through in or about November 1994. Respondent's care and treatment of Patient H failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of Patient H when Respondent began treating Patient H.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient H during the course of treatment of Patient H.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient H.

I. Respondent provided medical care to Patient I, for Dissociative Identity Disorder from in or about April 1991 through in or about May 1995. Respondent's care and treatment of Patient I failed to meet acceptable standards of care in that:

1. Respondent failed to obtain in a timely manner and/or record an adequate history and/or mental status evaluation of Patient I when Respondent began treating Patient I.
2. Respondent failed to obtain and/or record adequate supplemental histories and/or mental status evaluations of Patient I during the course of treatment of Patient I.
3. Respondent failed to maintain a record which adequately reflects the care, treatment and evaluation of Patient I.
4. Respondent failed to coordinate with Patient I's psychotherapist and/or record such coordination.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education 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:

1. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and all its subsections, A and A.5, A and A.6, A and A.7, B and B.1, B and B.2, B and B.3 and all its subsections, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3 and/or I and I.4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education 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:

2. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and all its subsections, A and A.5, A and A.6, A and A.7, B and B.1, B and B.2, B and B.3 and all its subsections, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3 and/or I and I.4.

THIRD SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6) by practicing the profession of medicine with gross incompetence as

alleged in the facts of the following:

3. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and all its subsections, A and A.5, A and A.6, A and A.7, B and B.1, B and B.2, B and B.3 and all its subsections, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3 and/or I and I.4.

FOURTH THROUGH TWELTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

4. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4 and all its subsections, A and A.5, A and A.6 and/or A and A.7.
5. The facts in paragraphs B and B.1, B and B.2, B and B.3 and all its subsections, B and B.4, B and B.5 and/or B and B.6.
6. The facts in paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.
7. The facts in paragraphs D and D.1, D and D.2, D and D.3 and/or D and D.4.
8. The facts in paragraphs E and E.1, E and E.2, E and E.3 and/or E and E.4.
9. The facts in paragraphs F and F.1, F and F.2, F and F.3 and/or F and F.4.
10. The facts in paragraphs G and G.1, G and G.2, G and G.3 and/or G and G.4.
11. The facts in paragraphs H and H.1, H and H.2 and/or H and H.3.
12. The facts in paragraphs I and I.1, I and I.2, I and I.3

and/or I and I.4.

THIRTEENTH AND FOURTEENTH SPECIFICATIONS

MORAL UNFITNESS

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

13. The facts in paragraphs A and A.4 and all subparts.
14. The facts in paragraphs B and B.3.a., B and B.3.b., B and B.3.c., B and B.3.e., B and B.3.f., B and B.3.g., B and B.3.h., B and B.3.i., B and B.3.j. and/or B and B and B.3.k.

FIFTEENTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law section 6530 (2) by his practicing the profession fraudulently as alleged in the facts of the following:

15. The facts in paragraphs B and B.5.

SIXTEENTH SPECIFICATION

PHYSICAL CONTACT OF A SEXUAL NATURE BETWEEN

A PSYCHIATRIST AND A PATIENT

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

16. The facts in paragraphs A and A.4.a.

SEVENTEENTH SPECIFICATION
EXERCISING UNDUE INFLUENCE
FOR FINANCIAL GAIN OF RESPONDENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(17) by exercising undue influence on a patient in such manner as to exploit the patient for the financial gain of the Respondent, as alleged in the facts of the following:

17. The facts in paragraphs B and B.3.a., B and B.3.b., B and B.3.c., B and B.3.h., B and B.3.j, and/or B and B.3.k.

EIGHTEENTH AND NINETEENTH SPECIFICATIONS
REVEALING OF PERSONALLY IDENTIFIABLE FACTS,
DATA OR INFORMATION OBTAINED IN A PROFESSIONAL
CAPACITY WITHOUT PRIOR CONSENT OF THE PATIENT

Respondent is charged with committing professional misconduct as defined by New York Educ. Law §6530(23) by revealing personal information of a patient without consent as alleged in the facts of the following:

18. The facts in paragraphs A and A.4.c., A and A.4.d. and A and A.4.h.
19. The facts in paragraphs B and B.3.d., B and B.3.f., B and B.3.g. and/or B and B.4.

TWENTY THROUGH TWENTY-EIGHTH SPECIFICATIONS
FAILURE TO MAINTAIN ACCURATE 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 evaluation and treatment of the patient, as alleged in the facts of the following:

20. The facts in paragraphs A and A.2 and/or A and A.3.
21. The facts in paragraphs B and B.2.
22. The facts in paragraphs C and C.1, C and C.2 and/or C and C.3.
23. The facts in paragraphs D and D.1, D and D.2 and/or D and D.3.
24. The facts in paragraphs E and E.1, E and E.2 and/or E and E.3.
25. The facts in paragraphs F and F.1, F and F.2 and/or F and F.3.
26. The facts in paragraphs G and G.1, G and G.2 and/or G and G.3.
27. The facts in paragraphs H and H.1, H and H.2 and/or H and H.3.
28. The facts in paragraphs I and I.1, I and I.2 and/or I and I.3.

DATED: *October 20, 1998*
Albany, New York

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

by w.f.