



**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

433 River Street, Suite 303

Troy, New York 12180-2299

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC April 15, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Charles E. Breen, M.D.
808 Carroll Street
Brooklyn, New York 11215

George Weinbaum, Esq.
Counsel for Respondent
11 Martine Avenue, 12th Floor
White Plains, New York 10606

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001

RE: In the Matter of Charles Breen, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 04-79) 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

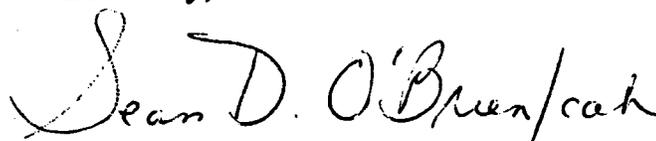
The notice of review served on the Administrative Review Board should be forwarded to:

**James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180**

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

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

Sincerely,

A handwritten signature in cursive script that reads "Sean D. O'Brien/cab". The signature is written in dark ink and is positioned above the typed name.

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah
Enclosure

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

**IN THE MATTER
OF
CHARLES BREEN, M.D.**

**DETERMINATION
AND
ORDER
BPMC 04 -79**

COPY

Milton O. C. Haynes, M.D. (Chairperson), Martha L. Crowner, M.D., and Linda Prescott Wilson, 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. Marc P. Zylberberg, Esq., Administrative Law Judge, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. Respondent, Charles Breen, appeared personally and was represented by the Law Offices of George Weinbaum by George Weinbaum, 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:

September 3, 2003

Date of Service of Notice of Hearing and
Statement of Charges:

September 5, 2003

Date of Answer to Charges:	September 26, 2003
Pre-Hearing Conference Held:	September 29, 2003
Hearings Held: - (First Hearing day):	October 8, 2003; October 27, 2003; November 19, 2003; December 8, 2003; January 12, 2004
Intra-Hearing Conferences Held:	October 8, 2003; October 27, 2003; November 19, 2003
Location of Hearings:	Offices of New York State Department of Health 5 Penn Plaza, 6 th Floor New York, NY 10001
Witnesses called (in the order they testified) by the Petitioner, Department of Health:	Alexander Caemmerer, Jr., M. D.; Patient A ¹
Witnesses called (in the order they testified) by the Respondent, Charles Breen, M.D.:	Susan Breen; Valerie Heller, M.A.; Charles Eugene Breen, M.D.; Laurence Loeb, M.D.
Respondent's Post-Hearing Memorandum:	Received February 17, 2004
Department's Summation, Proposed Findings of Fact, Conclusions of Law and Recommended Sanction:	Received February 23, 2004
Deliberations Held: (last day of Hearing)	March 8, 2004

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

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

New York ["P.H.L."]). 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. Charles Breen, M.D. ("Respondent") is charged with six (6) 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) practicing the profession with gross negligence²; (2) practicing the profession with negligence on more than one occasion³; (3) practicing the profession with gross incompetence⁴; (4) practicing the profession with incompetence on more than one occasion⁵; (5) having physical contact of a sexual nature between the licensee (a psychiatrist) and a patient⁶; and (6) failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient⁷.

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct towards one patient from 1991 through 1997. Respondent admits to treating Patient A but denies that his treatment of Patient A failed to meet accepted medical conduct. Respondent denies the factual allegations and the Specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges and the Answer is attached to this Determination and Order as Appendix 1 and Appendix 2 respectively.

² Education Law §6530(4) - (the First Specification of the Statement of Charges [Department's Exhibit # 1].

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

⁴ Education Law §6530(6) - (the Third Specification of the Statement of Charges [Department's Exhibit # 1].

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

⁶ Education Law §6530(44)(a) - (the Fifth Specification of the Statement of Charges [Department's Exhibit # 1].

⁷ Education Law §6530(32) - (the Sixth Specification of the Statement of Charges [Department's Exhibit # 1].

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. 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 on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

General Findings

1. Respondent, who maintained a general psychiatric practice, was licensed to practice medicine in New York State on August 30, 1971 by the issuance of license number 109682 by the New York State Education Department (Department's Exhibit # 2)⁸.
2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); (Department's Exhibit # 1); [P.H.T-5-6]⁹.
3. Physical contact of a sexual nature between a psychiatrist and a patient is prohibited. The sexual contact can cause significant damage to the patient [T-101, 568, 591, 592, 601, 877].
4. A psychiatrist who has engaged in sexual contact with a patient (hugging, kissing, conducting therapy with the patient on psychiatrist's lap) has lost medical and professional judgment and has overstepped medical and ethical bounds [T-103-105, 568, 569, 591].

⁸ Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Charles Breen (Respondent's Exhibit #).

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

5. A psychiatrist needs to maintain objectivity during the therapy of a patient [T-105-106].
6. A patient may be seductive to a psychiatrist. It is the psychiatrist's responsibility to resist seduction [T-119, 594, 891].
7. A thorough psychiatric evaluation must be performed at the initial patient encounter with a Psychiatrist. This evaluation includes information about the patient's present illness, family history, psychiatric examination of the mental status including orientation, memory, affect, and description of symptomatology, if any. The psychiatrist should then make a diagnosis, if possible, and that diagnosis is part of the evaluation. This evaluation must be recorded in the medical records of the patient and maintained by the psychiatrist [T-37-38].
8. After the initial evaluation, the psychiatrist needs to continue to document the patient's psychodynamics, as well as the clinical situation (ie: is the patient depressed, anxious, sleeping, or appetite effected). If the patient is on medication, the psychiatrist must document, in the patient's medical records, the medication, the dose, side effects, if any, and the therapeutic effects of the medication, if any [T-39].
9. The information obtained by the psychiatrist from the patient and the psychiatrist's analysis of the patient's mental status must be recorded in the patient's medical records in case the psychiatrist is unavailable and/or the patient must be treated by another physician. This information should be recorded after each visit [T-39-40, 863].

PATIENT A

10. From 1991 through 1997, Respondent treated Patient A, a psychiatric patient, in his office located at 808 Carroll Street, Brooklyn, N.Y. Respondent also treated Patient A at Methodist Hospital, Brooklyn, N.Y. (Department's Exhibits # 3, 4, 5, 5A, 6, and 6A); (Respondent's Exhibit # A).

11. Respondent had, at least, the following inappropriate physical sexual contact with Patient A from late 1991 through 1997:

A. Respondent placed his tongue in Patient A's mouth during a kiss (Department's Exhibit # 4 @ 523, 563); [T-286, 669, 741].

B. Respondent kissed Patient A twice on the lips (Department's Exhibit # 4 @ 178, 181, 182, 523, 525, {196-198 - April 6, 2000 transcript}).

C. Respondent kissed Patient A on her cheeks and forehead (Department's Exhibit # 4 @ 526, 527); [T-744].

D. On numerous occasions, Respondent placed his arms around Patient A and hugged her (Department's Exhibit # 4 @ 178, 299-301, 451, 453, 454, 457, 458, 463, 464, 468, 471, 507, 508, 538, 519, 538, 553, {105, 203, 204, 221 - April 6, 2000 transcript}); [T-749].

E. Patient A sat on Respondent's lap and he conducted therapy with her on his lap (Department's Exhibit # 4 @ 473, 474, 480, 519, {51, 52 - April 6, 2000 transcript}); [T-277-282, 412-413, 752-754].

F. Respondent rubbed aloe lotion on Patient A's body (Department's Exhibit # 4 @ 57-65 - April 6, 2000 transcript); [T-765].

G. Respondent hugged Patient A on numerous occasions before, during, and at the end of therapy sessions [T- 274, 276, 398 ,410, 429].

12. Respondent's initial psychiatric evaluation of Patient A failed to meet minimum accepted medical standards and was not appropriate. Respondent failed to record a thorough history, including, a family history, personal history, developmental history, list of symptoms, description of symptoms, and mental status examination. The medical records contain a diagnosis without any indication of Respondent's rationale (Department's Exhibit # 3); [T-50].

13. Respondent's notes of his ongoing treatment of Patient A were deficient and inadequate. Most of the notes detail the various alters of Patient A rather than commenting about the level of depression or Patient A's suicidal indications. Respondent rarely recorded the medications the patient used in her overdoses. The notes in Patient A's medical records were sporadic and diagrammatic (Department's Exhibit # 3); [T-50-52, 57, 932-936].

14. The medical records of Patient A contain very little information about her mental status over the course of more than 6 years of treatment. The notes mostly contain conversations or material pertaining to Patient A's various alters. Respondent's records failed to contain analysis of Patient A's mental health, and only repeated the patient's description of her various alters. Patient A's medical records did not contain adequate treatment information (Department's Exhibit # 3); [T-58, 711, 932].

15. Respondent failed to record and document, in her medical record, the numerous prescriptions that he provided to Patient A. Respondent wrote more than three hundred (300) prescriptions, only a small fraction of those were noted in Patient A's medical record. Respondent rarely recorded the reason for issuing prescriptions to Patient A. Respondent failed to note the doses, the amount prescribed, the names of drugs prescribed, and information about refills (Department's Exhibits # 3, 5, 5A, 6, and 6A); [T-45-50, 58-61, 901].

16. Respondent's 34 prescriptions for Oxycodone, Percodan and Percocet (narcotic painkillers) to Patient A was a significant deviation from accepted medical standards. Nothing in the record supported the need for these medications [T-63-65, 69, 70, 734].

17. Respondent issued 97 prescriptions of Lorazepam to Patient A, without any indication for the prescription and without documentation as to Patient A's response to this medication. This prescribing practice was a significant deviation from accepted medical standards (Department's Exhibits # 3, 5, 5A, 6, 6A); [T-71-74].

18. Respondent regularly prescribed (46 prescriptions) Temazepam, a sleeping pill, to Patient A. Respondent failed to adequately document in the record any need for this medication (Department's Exhibits # 3, 5, 5A, 6, 6A; [T-74]).

19. Respondent also prescribed Chlorpromazine (also known as Thorazine), Perphenazine (also known as Trilafon) and Thioxanthene (also known as Navane) all anti-psychotics, to Patient A. Respondent failed to document any reason why Patient A required these medications. Respondent never monitored or recorded Patient A's responses to these medications (Department's Exhibits # 3, 5, 5A, 6, 6A; [T-75, 78, 79]).

20. Patient A overdosed at least 17 times while under Respondent's care. After each overdose, Respondent gave Patient A a fresh set of prescriptions. Respondent's prescription practices significantly deviated from accepted medical standards. (Department's Exhibit # 3); [T-87, 301, 397].

CONCLUSIONS OF LAW

The Hearing Committee makes the conclusion pursuant to the Findings of Fact listed above, by a unanimous vote, that Factual Allegations A. and A.1 through A.7 contained in the September 3, 2003 Statement of Charges are **SUSTAINED**.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by a unanimous vote, concludes that **ALL THE SPECIFICATIONS OF MISCONDUCT** contained in the Statement of Charges are **SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with six (6) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled: Definitions of Professional Misconduct under the New York Education Law¹⁰. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

Gross Negligence

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 Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Negligence on More Than One Occasion

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. Breen caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to

¹⁰ A copy was made available to both parties at the First day of the Hearing [P.H.T-20-22]; [T-4-7].

a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

The failure to maintain records which accurately reflect the evaluation and treatment of the patient and which does not affect patient treatment will not constitute negligence. Where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may constitute negligence.

Gross Incompetence

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

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. These factors may include the Hearing Committee's impression of Dr. Breen's technical knowledge and competence on the various issues and the charges under consideration.

The ALJ also instructed the Hearing Committee of the following commonly understood concepts:

Failure to Maintain Records

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. In making a determination of the adequacy of the records in question, the Hearing Committee must be guided by the testimony of the witnesses presented by both parties.

Preponderance of the Evidence

The burden of proof in these proceedings 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. 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 Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

The Hearing Committee used ordinary English usage and understanding for all other 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, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence. The Hearing Committee understood that as the trier of fact we may accept so much of a witnesses' testimony as is deemed true and disregard what we find and determine to be false.

In accordance with the above understanding, the Hearing Committee determined that all of the allegations and all of the charges contained in the Statement of Charges were established by a preponderance of the evidence.

Dr. Alex Caemmerer testified as the Department's expert. Dr. Caemmerer is a member of the American Psychiatric Association and is board-certified in psychiatry. Dr. Caemmerer opened a private office in 1952 and has been practicing general psychiatry since then. Dr. Caemmerer is licensed in New York State and in New Jersey. Dr. Caemmerer is no longer registered to practice in New York State (Department's Exhibit # 7).

Dr. Laurence Loeb testified as Respondent's expert. Dr. Loeb is a distinguished life fellow of the American Psychiatric Association and is board-certified in psychiatry and in forensic psychiatry. Dr. Loeb has been in practice since 1954 and has extensive teaching and publication

credentials (Respondent's Exhibit # D). Both Dr. Caemmerer and Dr. Loeb were found to be credible and critical of Respondent's conduct and of the medical records he maintained for Patient A.

Respondent's own sworn testimony, both at the Hearing and at the four examinations before trial ("EBT"), was sufficient to sustain the charges brought against him by the Department. Patient A's testimony did not add or deduct from Respondent's culpability and responsibility.

The Hearing Committee determines that kissing, as occurred in this case, is sexual contact. The Hearing Committee determines that hugging, as occurred in this case, is sexual contact. The Hearing Committee determines that straddling on Respondent's lap, as occurred in this case, is sexual contact. The Hearing Committee determines that the extensive touching of the patient by Respondent had little if any apparent therapeutic value. The Hearing Committee concludes that on numerous occasions between 1991 and 1997 Respondent engaged in sexual contact with Patient A.

In addition to Respondent's own testimony, the medical records of Patient A clearly prove that Respondent failed to perform adequate psychiatric examinations of Patient A. The medical records are difficult to follow. They are written more as a diary than medical records. They contain very little information regarding treatment, assessment, prognosis or plan of action. They contain very little information regarding the patient's suicidal ideations. The medical records maintained by Respondent for Patient A failed to contain adequate treatment information and failed to document the medications Respondent prescribed. The medical records also failed to contain reasons for the prescriptions, reactions to the prescriptions and medical indication or necessity for the prescriptions.

The Hearing Committee determines that taken together, the sexual contact, the inadequate psychiatric examinations, the wholly inadequate medical records and the prescription pattern, result in a finding of gross negligence committed by Respondent. The Hearing Committee also finds that

Respondent has committed negligence on more than one occasion as demonstrated each time he had sexual contact with Patient A. His negligence is also demonstrated each time he failed to document Patient A's reaction to the prescribed medications, and demonstrated each time he prescribed medication to Patient A without medical indication. Respondent's negligence is further demonstrated each time he prescribed narcotics to Patient A.

Respondent admitted that he was "in over his head". Yet Respondent continued to "treat" Patient A. Respondent did not seek appropriate help nor did he change treatment even when it was offered by Dr. Nayak, the Director of the Department of Psychiatry at New York Methodist Hospital. As Dr. Nayak indicated, in his memorandum to Dr. Breen (Assistant Attending), dated September 12, 1994 entitled MANAGEMENT ISSUES ON PATIENT (Department's Exhibit # 3 @ 289-290):

... There were unanimous concerns regarding certain irregularities in your approach to this patient.

1. In the last 2 ½ years she has been admitted 17 times to NY Methodist Hospital for suicidal behavior or thoughts. Yet you never focus on treatment of chronic suicidal tendencies but exclusively on the multiple-personalities that patient presumably has. Your treatment plans and progress notes hardly ever discuss behavioral management of suicidal thought or preventative steps you have taken to reduce recidivism.

2. You blatantly defy the opinions of respectable team members such as Dr.'s Krugley, Fein, Mr. Carrington and other nursing staff. They know your patient reasonably well, but you insist on operating outside the team influence claiming that the team has no jurisdiction over your patient.

3. Dr. Krugley and I have had several private conversations with you on this patient to no avail. Last year I wrote you a letter asking you to refer the patient elsewhere as:

a. the unit has no expertise in the treatment of multiple-personality disorders and,

b. the team members (including myself) were unhappy with your treatment plans for this patient.

You have continued to bring the patient to NY Methodist but still are unwilling to work with the team e.g., you refused to let the team interview the patient on 9/12 and later told my secretary that "you cannot comply with directions from rounds". There are other instances of unprofessional behavior. 1) you reportedly woke up the patient at 12:30 a.m. to have a session with her. 2) you bent the policies of the unit to accommodate her personal needs (e.g., you once gave her a pass to attend a concert). I am also concerned about a certain case with which you dispensed benzodiazepines to her and this was highlighted in my letter of 12/15/93.

Unless you are willing to ponder these issues and convey your willingness to work with the team, I will seriously consider blocking future admissions of this patient to NY Methodist.

The Hearing Committee determines that Respondent showed a marked lack of the skill or knowledge necessary to provide psychiatric care for Patient A, an act undertaken by Respondent in the practice of medicine. The gross incompetence consisted of multiple acts of incompetence that cumulatively amounted to egregious conduct. We also determined that Respondent's incompetence was egregious because the incompetence occurred for so long a period of time and Respondent continued to refuse help on a number of occasions that it was offered to him. Respondent also failed to use the help that was available to him. The Hearing Committee also determines that Respondent practiced the profession of medicine with incompetence on more than one occasion. One of the more troubling aspects of Respondent's incompetence was his own knowledge that he was in way over his head but did not or could not bring himself to act in the best interest of his patient. Respondent did not seek supervision nor did he terminate treatment and refer Patient A for appropriate competent treatment.

The Hearing Committee also sustains the charge that Respondent committed professional misconduct by failing to maintain a record for Patient A which accurately reflects the care and treatment of the patient.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented during 5 days of Hearing and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, a majority of 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) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service; and (10) Probation.

The Hearing Committee extensively discussed the appropriate penalties necessary to address Respondent's misconduct in this case. In the final analysis the Hearing Committee had to decide on one of two options: either Respondent's license should be revoked and Respondent should have an opportunity to reapply for his license after the expiration of three years; or, Respondent's license should be suspended for a lengthy period of time, at least three years, and he should be placed on probation, with certain conditions, including mandatory therapy, retraining on ethical and boundary issues, retraining on medical record keeping, and supervision in an article 28 facility.

Sexual contact between a psychiatrist and a patient constitutes a fundamental violation and exploitation of trust so as to warrant a penalty of revocation. Sexual contact between a psychiatrist and a patient with a history of prior sexual abuse constitutes an egregious, severe breach and

exploitation of trust. Respondent's conduct demonstrates that he does not possess the necessary self-control, knowledge and abilities to practice medicine. Respondent's prescription patterns, medical record keeping patterns, and failure to properly treat Patient A warrant a penalty of revocation.

The Hearing Committee understood that Respondent did not necessarily do well in an unstructured setting and was not cooperative in a hospital setting either, as evidenced by the September 12, 1994 memorandum quoted above. An aggravating factor was the length of time that Respondent's misconduct continued. Respondent was adrift, refusing help for many years to the detriment of Patient A, admittedly a very difficult and controlling patient. Another aggravating factor was Respondent's prescription practices towards Patient A, which was equal in weight of misconduct as the sexual contact misconduct.

Some of the mitigating factors against revocation include Respondent's acknowledgment of his errors and failings (although his testimony to the Hearing Committee was somewhat different than his EBT testimony). Respondent did not have sexual intercourse with Patient A. He no longer takes patients with multiple personality disorders. Patient A was a very difficult patient.

A majority of the Hearing Committee believes that Respondent would not respond well to retraining and working under supervision. Respondent showed some inability to make a clean break and admit his errors by offering continued justification or explanation for some of his misconduct. A majority of the Hearing Committee concludes that the aggravating factors outweighed the mitigating factors. A majority of the Hearing Committee concludes that Respondent does not have enough insight and understanding of his own limitations to be trusted to practice medicine in the State of New York. A majority of the Hearing Committee believes that it should be up to Respondent to demonstrate to a restoration committee that he should be allowed to practice, as

opposed to placing the burden on the Department to attempt to rehabilitate Respondent. One member of the Hearing Committee was against revocation but believes that Respondent's license should be suspended for a lengthy period of time (between 3 and 5 years).

The Respondent's request to have Dr. Caemmerer's testimony totally stricken from the record was denied by the ALJ and is denied by the Hearing Committee. The fact that Dr. Caemmerer was not registered in New York State when he testified has no bearing on his expertise. The possibility that Dr. Caemmerer and the prosecutor did not comply with the ALJ's order to not discuss his testimony or any facts of the case was considered by the Hearing Committee in the weight that they gave to Dr. Caemmerer's testimony. In any event, as indicated above, Respondent's own testimony at the Hearing and at the four EBTs' held in 1999 and 2000, together with the records admitted in evidence, were sufficient to sustain all the charges.

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.

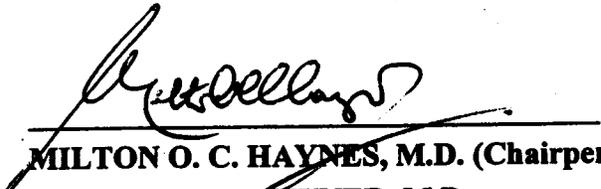
By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The **FIRST, SECOND, THIRD, FOURTH, FIFTH and SIXTH SPECIFICATIONS** contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and
2. All Factual Allegations contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and
3. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and
4. This Order shall be effective on personal service on the Respondent or 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
April, 14, 2004


MILTON O. C. HAYNES, M.D. (Chairperson)
MARTHA L. CROWNER, M.D.
LINDA PRESCOTT WILSON

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New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, NY 10001

APPENDIX 1

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

IN THE MATTER
OF
CHARLES BREEN, M.D.

STATEMENT
OF
CHARGES

CHARLES BREEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 30, 1971, by the issuance of license number 109682 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. From in or about 1991 through 1997, Respondent treated Patient A (identified in attached Appendix), a psychiatric patient, in his office located at 808 Carroll Street, Brooklyn, N.Y., and also at Methodist Hospital, Brooklyn, N.Y. Respondent's treatment of Patient A failed to meet accepted medical conduct, in that:
1. On numerous occasions during the period of 1991 through 1997, Respondent engaged in sexual contact with Patient A.
 2. Throughout the period of 1991 through 1997, Respondent failed to perform adequate psychiatric examinations of Patient A.
 3. Respondent's medical record for Patient A failed to contain adequate treatment information.
 4. Respondent failed to document the medications he prescribed to

Patient A.

5. Respondent failed to document Patient A's reaction to the prescribed medications.
6. Respondent frequently prescribed pain medication to Patient A without any medical indication documented in the chart.
7. Respondent inappropriately prescribed central nervous system depressants to a highly suicidal patient.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraph A and its subparagraphs.

SECOND 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:

2. Paragraph A and its subparagraphs.

THIRD 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:

3. Paragraph A and its subparagraphs.

FOURTH 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:

4. Paragraph A and its subparagraphs.

FIFTH 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 psychiatrist having physical contact of a sexual nature between the licensee and the patient, as alleged in the facts of:

5. Paragraph A and A 1.

SIXTH 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:

6: Paragraph A and its subparagraphs.

DATED: September 3, 2003
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

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

copy

IN THE MATTER
OF
CHARLES BREEN, M.D.

RESPONDENT'S
ANSWER TO
THE STATEMENT
OF CHARGES

ORIGINAL

FILE
Respondent A In Error
9-29-03
ACCU SURVEILLANCE DIVISION, INC. MS 8

Charles Breen, M.D., the Respondent, by his attorney, George Weinbaum Esq., as and for his Answer to the Statement of Charges, alleges as follows:

FACTUAL ALLEGATIONS

A. Admits in or about 1991 through 1997, Respondent treated Patient A, a psychiatric patient, in his office located at 808 Carroll Street, Brooklyn NY and also at Methodist Hospital, Brooklyn NY, but denies his treatment of Patient A failed to meet accepted medical conduct.

1. Dr. Breen denies on numerous occasions during the period of 1991 through 1997 engaging in sexual contact with Patient A.
2. Denies throughout the period of 1991 through 1997 failing to perform adequate psychiatric examinations of Patient A.
3. Denies that the medical record for Patient A failed to contain adequate

treatment information.

4. Denies that he failed to document medications prescribed.
5. Denies that he failed to document Patient A's reaction to the prescribed medication.
6. Denies frequently prescribing pain medication to Patient A without medical indication documented.
7. Denies inappropriately prescribing central nervous system depressants to a highly suicidal patient.

SPECIFICATIONS OF CHARGES

Respondent denies each and every one of the specifications of professional misconduct, denies he engaged in any conduct which would warrant the sustaining of any specification. However, he does admit to kissing Patient A on one occasion, wherefore, he does demand a hearing.

AS AND FOR AN AFFIRMATIVE DEFENSE

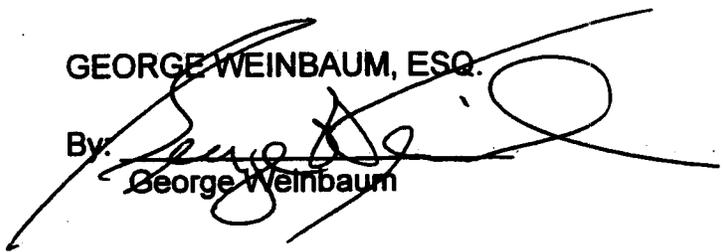
All of the allegations in this case will be resolved on the basis of whether or not clinical judgement was appropriately exercised under the existing circumstances and whether or not documentation of the care provided was adequate. These issues should be resolved in a quality assurance or in academic debate, not in disciplinary proceeding which places at risk the licensure and reputation of a physician who spent years providing professional care to psychiatric patients.

WHEREFORE, Charles Breen, M.D., requests a determination be issued dismissing the Statement of Charges in its entirety and granting such other and further relief as may be just.

Date: _____
White Plains, NY

**To: Diane Abeloff, Esq.
NYS Department of Health
Office of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York NY 10001**

GEORGE WEINBAUM, ESQ.

By: 
George Weinbaum

**Attorney for Charles Breen, M.D.
11 Martine Avenue 12th Floor
White Plains NY 10606**

**cc: Administrative Law Judge
NYS Department of Health
433 River Street 5th Floor
Troy NY 12180-2299
Attn: Hon. Marc P. Zylberberg, Esq.**