

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

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

Dennis P. Whalen
Executive Deputy Commissioner

May 18, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leni S. Klaimitz, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Matthew Miller, M.D.
42-07 30th Avenue
Astoria, New York 11103

Richard W. Nicholson, Esq.
Schiavetti, Geisler et al.
1633 Broadway
New York, New York 10019

RE: In the Matter of Matthew Miller, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-99) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Handwritten signature of Tyrone T. Butler in cursive script.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER
OF
MATTHEW MILLER, M.D.

DETERMINATION
AND
ORDER

BPMC-98-99

STANLEY GITLOW, M.D., Chairperson, ARTHUR N. TESSLER, M.D. and
KENNETH KOWALD, duly designated members of the State Board for Professional Medical
Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section
230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to
Section 230(10)(e) of the Public Health Law. JEFFREY ARMON, ESQ., served as
Administrative Officer for the Hearing Committee. After consideration of the entire record, the
Hearing Committee submits this Determination.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	October 22, 1997
Prehearing Conference	November 24, 1997
Dates of Hearing:	November 24, 1997 December 8, 1997 January 5 and 22, 1998
Department of Health appeared by:	Henry M. Greenberg, General Counsel NYS Department of Health
BY:	Leni S. Klaimitz, Esq. NYS Department of Health 5 Penn Plaza, Suite 601 New York, New York 10001
Respondent appeared by:	Richard W. Nicholson, Esq. 1633 Broadway New York, New York 10019

Witnesses for the Department of Health: Patient B
Steven Barry Tamarin, M.D.

Witnesses for the Respondent: Stacey Karamanlakis
Richard Tobin
Matthew Miller, M.D.
(Respondent)

Receipt of Final Written Submissions: February 27, 1998

Deliberations held: March 9, 1998

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's exhibits are designated by Letters.
T = Transcript

A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix I.

GENERAL FINDINGS OF FACT

A. The Respondent was authorized to practice medicine in New York on or about June 19, 1981 by the issuance of license number 148343 by the New York State Education Department. (Ex.2)

B. Respondent is a primary care physician with a general practice in family medicine.
(T. 296-7)

FINDINGS OF FACT RELATED TO PATIENT A

1. Respondent first treated Patient A, a male aged 28 at that time, for a check-up on April 14, 1987. The medical record maintained by Respondent indicated no complaints by the patient. A history of a prior appendectomy, otitis, lumbar surgery and disc disease was noted. Respondent recorded that the parents of the patient were alive and well; that Patient A had quit smoking three years previously and that he occasionally used alcohol. (Ex. 4, pp. 2-3; T. 349-50)

2. Respondent performed and recorded findings from a review of the patient's systems. Positive findings included dizziness associated with otitis, gastro-intestinal system remarkable for a history of diarrhea and a history of low back pain. (Ex. 4, pp. 2-3; T.349-50)

3. Respondent performed and recorded the findings of a physical examination of the patient, including blood pressure, weight, skin, eyes, ears, nose, throat, pharynx, tonsils, neck, chest, heart, lungs, abdomen and extremities. A diagnosis of colitis was made and an antispasmodic, Bentyl, was prescribed as treatment. (Ex. 4, p. 3; T. 350-2)

4. Respondent next treated Patient A on September 25, 1992 for a complaint of left sciatic pain. A history of lumbar surgery with removal of four lumbar discs during two separate surgical procedures was recorded. Respondent performed a physical examination of the patient's back and legs, observed his gait, checked the range of motion, strength of extremities, straight leg raising, tendon reflexes and skin sensation. A finding of tenderness on the left side of the lumbar spine at the L4, L5 level was noted. Respondent treated the patient with an injection of Decadron, Decadron L.A. and Marcaine, long and short-acting cortisone medications with a local anesthetic. A transcutaneous electrical nerve stimulator (TENS Unit) was applied and Toradol, an anti-inflammatory analgesic, and Percocet were prescribed. (Ex. 4, p. 4; T. 353-6)

5. Between September 25, 1992 and March 15, 1995, Respondent saw Patient A on twenty-eight occasions, primarily in response to complaints of lower back pain. Throughout that period, Respondent saw the patient on an average of about every four to six weeks and continued to prescribe Percocet, a narcotic, to manage his pain. In response to the continuous complaint of lower back pain, Respondent performed a standard physical examination consisting of observation of the patient's gait, examination of the back, a check of tendon reflexes and range of motion, straight leg-raising and a test of the sensation and strength of the extremities. (Ex. 4, pp. 4-11; T. 164-5, 361, 365-6)

6. Respondent recommended that Patient A undergo an MRI study of his back on numerous occasions throughout the period of treatment. Respondent also recommended that the patient obtain physical therapy and a surgical consultation. An entry in the medical record dated October 6, 1993 indicated that the patient had no money for physical therapy; an entry dated February 11, 1995 noted that the patient "may need surgery". The patient did not comply with these recommendations and did not obtain such testing or services. (Ex. 4, pp. 4-7; T. 182, 362-5, 387-8)

7. Respondent last saw Patient A on March 15, 1995 before the patient moved out-of-state. He recorded in the medical chart an intent to "wean from Percocet" and reduced the amount of the prescription to thirty pills. (Ex. 4, p. 11)

FINDINGS OF FACT RELATED TO PATIENT B

8. Patient B, a 47 year old female, first saw Respondent for medical treatment on or about November 17, 1994. They had previously met when the patient accompanied the daughter of a former boyfriend to Respondent's office for medical care on several occasions. (Ex. 3, p. 2; T. 20-2, 406)

9. Patient B presented with a complaint of nervousness. Her complaints were not psychiatric in nature. She indicated that a lengthy live-in relationship had recently ended, that she was experiencing financial difficulties and that her consumption of alcohol had increased to about five to six drinks per day. (Ex. 3, pp.2-3; T. 22-3; 90, 406-7)

10. Respondent recorded a diagnosis of anxiety in the patient's medical record. He directed Patient B to discontinue her use of alcohol and prescribed Buspar and Valium as treatment. (Ex. 3, p.3)

11. Valium (generically dispensed as Diazepam) can be indicated in the treatment of alcoholism to assist in detoxification. (T. 226-7, 232-4)

12. On or about December 8, 1994, Patient B was taken into custody by police and transported to Booth Memorial Hospital. She was in an intoxicated and distressed state, having consumed alcohol and pills. Her medications were confiscated and not returned. The patient sent a letter, dated December 10, 1994, to Respondent which described these events. (Ex. 3, pp. 7-12, 17-8; T. 28-32)

13. Respondent treated Patient B on December 12, 1994 pursuant to a scheduled follow-up appointment. He prescribed Buspar and Valium to replace the confiscated medications. (Ex. 3, p.9; T. 28, 32-4, 409-10)

14. At the request of Patient B, who telephoned and indicated that she was not feeling well, Respondent made a house call to the patient's residence on the evening of December 21, 1994. During the course of that visit, they engaged in consensual sexual intercourse. (T. 38-40, 410-13)

15. Between approximately December, 1994 and April, 1996, Respondent and Patient B continued to engage in a consensual sexual relationship exclusively at the residence of the patient. Respondent continued to prescribe Valium, five milligrams two or three times per day, and Buspar for the patient. During this period of treatment, her daily consumption of alcohol decreased. (Ex. 3, pp. 3, 9, 14-5, Ex. 6, T. 42-4, 51-2, 58, 416-7, 438, 453-4)

16. During the same period, Respondent provided the patient medical treatment for various complaints. In June, 1995, he treated her complaint of right elbow pain. In July, 1995, Respondent treated Patient B following a sexual assault by prescribing antibiotics and performing a gynecological examination. In October, 1995, he treated her for a complaint of dysuria. In April, 1996 Respondent treated Patient B for bruises she received from an assault by a neighbor. Patient B made about eight visits to Respondent's office during this period. (Ex.3, pp. 14-15; T. 46-9, 52-3, 58-9, 131, 413)

17. In or about March, 1996, Patient B mailed a sexually suggestive greeting card to Respondent's receptionist. (T. 319)

18. The physician-patient relationship between the Respondent and Patient B ended in April, 1996. In that same month, Patient B made a complaint to the Office of Professional Misconduct (OPMC) regarding Respondent's conduct. On or about May 30, 1996, Patient B sent a letter to the OPMC indicating that she no longer wished to pursue such complaint. On or about June 12, 1996 Patient B advised the OPMC that she wished to reinstate the complaint and pursue an investigation into Respondent's conduct. (T. 112-14, 117-20, 132, 417-418)

19. Respondent began receiving counseling from a psychotherapist in or about November, 1997 to address the stresses associated with his relationship with Patient B. (T. 427, 449-50)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph B.1. (sustained in part only) : (14-16);

Paragraph B.2. : (14-16).

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that **NONE** of the Specification of Charges could be sustained.

DISCUSSION

Respondent was charged with multiple Specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories 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 certain types of professional misconduct.

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

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

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.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

The Hearing Committee found it necessary to evaluate the testimony of the witnesses to determine their credibility and the appropriate weight to be accorded to the testimony of each person. The Committee paid close attention to the demeanor and testimony of Patient B. Her responses on cross-examination were seen as being evasive and she appeared to be vindictive and unreliable in her testimony. The Committee considered her testimony to be completely lacking in credibility. She did not deny that she made certain demands on Respondent to assist her in a real estate transaction, which he refused because he believed it to be of questionable legality. The Committee also noted her change of mind in first filing a complaint, subsequently asking that no action be taken on it and then again following up on the complaint as evidence in confirmation of the Respondent's testimony that her actions were based on his refusal to accede to her financial demands. This possibility served to reduce the patient's credibility. The Committee could find no evidence that Respondent had used medications and/or gifts of alcohol as a means in controlling her. Obviously, Patient B could obtain alcohol for herself and by her own admission her medical condition improved progressively during the time period in question. The Committee felt that the patient's claim of intercourse at Respondent's office during active office hours and when the staff was present lacked credibility.

The Committee accorded little weight to the testimony of the Department's medical expert, Dr. Tamarin. It was believed that he was inaccurate on certain factual points regarding what constituted common medical practices. The Committee rejected his contention that Respondent deviated from accepted standards by not actively ensuring that Patient A obtain diagnostic testing or physical therapy. Dr. Tamarin was viewed as having a poor grasp of what constituted acceptable standards of medical practice. His discussion of the relative power held by the individuals in a physician-patient relationship was considered relevant; however it was observed that he was not familiar with the specific relationship of Patient B and Respondent and could not comment on their relative power. His unfamiliarity with the AMA's Code of Medical Ethics (Ex. 5), which the Department attempted to utilize as establishing a standard for the prohibition against sexual relationships between non-psychiatrists and their patients, further reduced the weight accorded his testimony.

Respondent appeared to be contrite and sincere. He indicated that he appreciated his errors and realized the costly results of his relationship with Patient B on his career and family. The fact that he is currently in counseling was noted. His testimony was viewed as credible when it conflicted with that given by Patient B. The testimony given by his receptionist concerning the mailing of the suggestive greeting card by Patient B was also considered credible. The Committee believed that the card was mailed to the receptionist and not to the Respondent, as alleged by Patient B in her testimony. This was seen as further evidence of an absence of the patient's credibility.

CONCLUSIONS RELATED TO PATIENT A

The Committee considered the history and physical examination of Patient A, as recorded by Respondent pursuant to the initial office visit of April 14, 1987, to have met acceptable standards of practice. A history of diarrhea was noted. The Committee believed that it would have been unjustified for Respondent to have ordered additional tests based on an initial visit and

general complaints that were not severe. Further studies would have been called for if the condition had persisted. Respondent's testimony that the term "colitis" was a "wastebasket" or generic term was accepted as an accurate description of its common usage and would be understood to refer to complaints of diarrhea and cramps. The prescription of the antispasmodic, Bentyl, was considered as appropriate to address complaints of cramps. Respondent adequately noted findings from his review of Patient A's systems and his performance of a physical examination. The absence of either a complaint or an appearance by Patient A in conjunction with his ultimate return as a patient to Respondent's office give credence to the accuracy of the Respondent's initial diagnosis and treatment. Factual Allegations A. 1. a. and A. 1. b. were not sustained.

Patient A returned to see Respondent more than five years later for a complaint of left sciatic pain. The history of two previous back surgeries was recorded. The Committee found Respondent's testimony that the patient sought symptomatic treatment and not additional surgery to be both credible and reasonable. The refusal of the patient to undergo additional back surgery was understandable and Respondent could only provide appropriate treatment that could enable the patient to engage in physical activities as free of pain as possible. The Committee felt it unnecessary for Respondent to seek Patient A's surgical records when his treatment was only for acute complaints. It was clear that the patient refused additional surgery. Respondent testified that he performed a standard physical examination of observation of the patient's gait, examination of his back, tendon reflexes and range of motion and performance of straight leg raising and sensation and strength of extremities tests. The Committee concluded that the history, physical examination and work-up of Patient A's complaints was adequate and appropriate under those circumstances. Factual Allegations A. 2. a., A. 2. b. and A. 2. c. were not sustained.

The Committee did not find it inappropriate for Respondent to prescribe Percocet to the patient to manage his pain. The history of a removal of four lumbar discs was considered as evidence of the patient's chronic back pain. Respondent testified that Patient A was able to work

and perform most normal daily activities with the assistance of the medication. The prescriptions were for small amounts and the patient was seen by the Respondent on a regular basis at his office. There was no evidence that the controlled substance was prescribed in an inappropriate manner. The medication was intended to manage the chronic pain experienced by a patient who refused additional surgery and who was unable to function without adequate analgesia. It was also observed that Respondent noted an intent to wean the patient from the Percocet at the final office visit of March 15, 1995. The Committee did not sustain Factual Allegation A. 2. d.

Factual Allegation A. 2. e. is inaccurate in that Respondent recommended MRI testing on more than three occasions. The record is clear that the patient refused referrals for diagnostic tests, physical therapy or consults with medical specialists. The Committee took strong exception to the suggestion by Dr. Tamarin that Respondent had a responsibility to ensure that Patient A complied with the referrals. It concluded that the Respondent was not required to force the patient to follow-up with referrals, particularly when it was clear that the non-compliance was based on an aversion toward further surgery. The Committee took Respondent's entry of February 11, 1995 as an indication that referral to a specialist was considered. Such a referral would have been fruitless. Factual Allegations A. 2. e. and A. 2. f. were not sustained.

The Committee believed that inclusion of charges of misconduct in the treatment of Patient A served to weaken the overall case brought against the Respondent. It could find no basis for bringing allegations of professional misconduct against Respondent for the care he rendered to Patient A.

CONCLUSIONS RELATED TO PATIENT B

Factual Allegations B. 1. and B. 2. set out the central issues of this proceeding. Respondent denied engaging in sexual intercourse with Patient B at any location other than her residence. The Committee found this testimony to be believable and the contention by the patient that they had engaged in intercourse at his Astoria medical office in or about June, 1995 to be

not credible. The balance of the two Factual Allegations was not disputed by Respondent. Accordingly, they were sustained by the Committee. The question as to whether such actions constituted professional misconduct will be addressed below.

The allegation that Respondent used his ability to prescribe medications to coerce Patient B to engage in a sexual relationship failed to be supported by any credible evidence. The amount of medication prescribed during the time period in question in conjunction with her gradual clinical improvement left no convincing evidence in the record to support such a charge. Respondent testified that while he did not refer her to another physician, she was always free to use another physician. In fact, the patient left the care of a physician who had treated her prior to the Respondent. The patient did not testify that Respondent threatened to not prescribe Valium or Buspar if she did not continue in their relationship. She also did not state that she became dependent on those medications. Respondent testified that the patient would assert that she was in control of her life, even during periods of personal difficulties. There was no evidence to suggest, during the entire period of their relationship, that it was anything other than consensual. Factual Allegation B. 3. was not sustained.

The Department's expert testified that prescribing Diazepam as treatment for alcoholism might be appropriate under certain circumstances for a short period. Factual Allegation B. 4. did not allege that Responent's treatment with Diazepam *for an extended period* was improper; the allegation was that the mere treatment with such medication was improper. The Committee considered testimony from both Respondent and Patient B that her daily consumption of alcohol decreased during her treatment with Diazepam as evidence that such treatment was appropriate. The prescription of Valium, five mg., two to three times per day was viewed as a relatively low maintenance- level amount. As noted above, Patient B never testified that she became dependent on the the drug. The Committee did not consider the treatment to be inappropriate and did not sustain Factual Allegation B. 4.

The Committee concluded that the medical record maintained by Respondent for Patient B met minimally acceptable standards and accurately reflected his care and treatment of

her. The consensual personal relationship would not have been expected to have been recorded and the failure to document such relationship was not seen as a deviation from accepted standards of practice. The records were considered to accurately document physical examinations, diagnoses and treatments of the patient. Factual Allegation B. 5. was not sustained.

SPECIFICATIONS OF PROFESSIONAL MISCONDUCT

Practice of the profession with negligence/ incompetence

The Committee concluded that Respondent's conduct in continuing to treat Patient B concurrent with a personal relationship did not constitute practice of the profession with negligence on more than one occasion or with gross negligence. It found that Respondent did not maintain a psychiatric practice and that his treatment of Patient B was not for psychiatric complaints. The Committee was instructed by the Administrative Law Judge that the definitions of professional misconduct found in Section 6530 of the New York Education Law does not address physical contact of a sexual nature outside of the practice of psychiatry and that there is not a statutory prohibition with respect to a consensual sexual relationship between a non-psychiatrist physician and a patient. It therefore concluded that the accepted standards of practice in such situations continue to evolve and the question of whether Respondent engaged in professional misconduct would have to be determined by the specific facts of this case. Despite the facts that only 30% of physicians are currently members of the American Medical Association and neither Respondent nor Dr. Tamarin was aware of the American Medical Association's Code of Medical Ethics regarding Sexual Misconduct in the Practice of Medicine (Ex. 5), it was reviewed by the Committee for guidance. The Code was seen as providing general guidelines only and not as establishing firm practice standards. The Committee could not conclude that Respondent failed to meet the standard of care that a reasonably prudent physician

would have exercised under similar circumstances. Under the facts presented, Respondent did not practice the profession with negligence.

There was no evidence that Respondent's treatment of either Patient A or B demonstrated a lack of skill or knowledge in the practice of medicine. The Committee concluded that the medical care provided to both patients was appropriate and met acceptable standards. Respondent was not found to have practiced with incompetence on more than one occasion or with gross incompetence.

Conduct in the practice of medicine evidencing moral unfitness to practice

The Committee agreed that a situation in which a non-psychiatrist physician continues to provide medical care to a patient while maintaining a personal relationship with that patient poses serious ethical questions. There was no intent to minimize the seriousness by concluding that whether such a situation constituted professional misconduct must be determined on a case-by-case basis. The Committee rejected the suggestion by the Department that the mere fact that Respondent had sexual relations with his patient was enough, in and of itself, to constitute professional misconduct. The relationship was clearly consensual and the patient was treated for non-psychiatric complaints. The Committee considered the directive of the AMA's Code of Medical Ethics which states, in part that " sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship." The Committee believed that such a directive would be even more applicable when the professional and personal relationships are concurrent. In the case at hand, the Committee unanimously concluded that there was no evidence of any exploitation of trust, knowledge, emotions or influence of Patient B by Respondent which would have caused their relationship to be considered as professional misconduct. The ethical guidance developed by the Board for Professional Medical Conduct during the past year was not relied on because there had been no general dissemination to the practicing physicians of New York State

and the acts charged in this case antedated the Board's determinations.

Dr. Tamarin testified as to the imbalance of power which usually is present in a personal relationship between a physician and patient. He spoke of the emotional dominance inherently held by the physician in such a situation which might make the relationship improper. On the other hand, his mention of the inherent "imbalance of power" failed to take into consideration that all intimate relationships suffer to a greater or lesser degree from such: one person might be older or younger, more wealthy, better educated, more handsome, smarter or more experienced. The Committee could not find such an imbalance present in the relationship between Respondent and Patient B. Personal observation of her demeanor and close examination of her testimony resulted in a conclusion that she was not a naive, immature, uneducated or inexperienced individual who was taken advantage of by the Respondent. While Patient B initially sought treatment for "nervousness" and excessive consumption of alcohol, there was no evidence presented which led the Committee to conclude that Respondent exploited the stresses in her life to engage in a sexual relationship. The patient herself stated that her drinking decreased as a result of the treatment provided by Respondent. There was no suggestion that the medical care provided for a variety of complaints, including two assaults by persons other than Respondent, was inappropriate or caused Patient B harm.

The Committee considered the changes of mind in filing a complaint, withdrawing it and subsequently reinitiating it as suggestive of an ulterior motive. It was noted that Respondent testified that she placed financial demands on him and desired that he leave his wife for her. While such factors did not excuse Respondent from his conduct, it also called into question the patient's purpose in submitting a complaint to the OPMC. The Committee found it unacceptable for the complaint process to be used as a vehicle for revenge, harassment or blackmail.

There was a strong belief that Respondent's conduct represented an isolated act of poor judgement. No evidence was presented to suggest that it represented a pattern of behavior. Respondent's wife and children have been seriously distressed by this entire episode and he is obviously making serious efforts to attempt to remain within his marriage. To that end, he is

currently, and has been for some time, in remedial psychotherapy. The Committee was impressed with Respondent's anguish concerning his behavior and its effects on his family and believed that any repetition of such an event to be unlikely. It concluded that the evidence in the record demonstrated that Respondent had not engaged in conduct evidencing moral unfitness to practice medicine and that the sustained Factual Allegations did not constitute professional misconduct.

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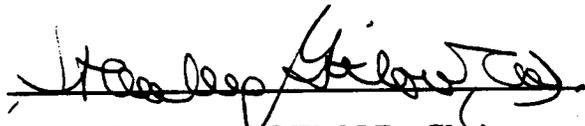
ORDER

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

1. All Specification of Charges are **NOT SUSTAINED** and are hereby **DISMISSED**,
and;
2. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York

May 15, 1998


STANLEY GITLOW, M.D., Chairperson

**ARTHUR N. TESSLER, M.D.
KENNETH KOWALD**

TO: Leni S. Klaimitz, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza- Suite 601
New York, New York 10001-1803

Matthew Miller, M.D.
42-07 30th Avenue
Astoria, New York 11103

Richard W. Nicholson, Esq.
Schiavetti, Geisler, et. al.
1633 Broadway
New York, New York 10019

APPENDIX I

IN THE MATTER
OF
MATTHEW MILLER, M.D.

STATEMENT
OF
CHARGES

MATTHEW MILLER, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 19, 1981, by the issuance of license number 148343 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Between on or about April 14, 1987 and on or about March 15, 1995, Respondent treated Patient A for colitis, sciatic pain and lower back pain at Respondent's medical offices located at 19-02 149 Street, Whitestone, NY 11357 and 42-07 30th Avenue, Astoria, NY 11103 (hereafter referred to as "his medical offices"). (The names of patients are contained in the attached Appendix).
1. On or about April 14, 1987 Respondent diagnosed Patient A with colitis and prescribed medication for that condition.
 - a. Respondent failed to obtain an adequate history.
 - b. Respondent failed to perform and/or note in his medical record for Patient A an adequate physical examination prior to making the above diagnosis and prescribing medication for the condition.

2. **Between on or about September 25, 1992 and on or about March 15, 1995, Patient A was seen by Respondent approximately twenty-eight times in his medical offices. On the great majority of these visits Respondent treated Patient A for lower back pain or sciatic pain.**

- a. **Respondent failed to obtain an adequate history of the lower back and sciatic pain.**
- b. **Respondent failed to perform and/or note in his medical record for Patient A adequate physical examinations.**
- c. **Respondent failed to perform and/or note an adequate work-up of Patient A's complaints.**
- d. **Respondent inappropriately prescribed Percocet to Patient A on at least fourteen of these visits.**
- e. **Respondent advised and/or prescribed MRI's on three occasions. Patient did not obtain an MRI. Respondent failed to make and/or note efforts to aid Patient A in obtaining this diagnostic procedure.**
- f. **During the course of Respondent's treatment of Patient A he failed to refer Patient A to a medical specialist for evaluation of the lower back pain and sciatic pain.**

B. Between on or about November 17, 1994 and on or about April 11, 1996 Patient B was under the care and treatment of Respondent. Respondent treated Patient B at his medical offices and at her residence. Respondent initially treated Patient B for anxiety.

- 1. Respondent developed a personal and sexual relationship with Patient B concurrent with their physician/patient relationship. Respondent engaged in sexual intercourse with Patient B in his medical office and at her residence.**
- 2. Respondent continued to treat Patient B after the establishment of their personal and sexual relationship.**
- 3. Respondent prescribed Diazepam and prescribed and dispensed Buspar to Patient B in order to exercise influence over Patient B for the purpose of engaging in a sexual relationship with her.**
- 4. Respondent inappropriately prescribed Diazepam to Patient B.**
- 5. Respondent failed to maintain a medical record for Patient B which accurately reflected Respondent's treatment of Patient B.**

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct under N.Y. Education Law Sec. 6530(4)(McKinney Supp. 1997) in that he practiced with gross negligence as alleged in the following facts:

1. Paragraphs A and A(1) and each and every subparagraph thereof, through A(2) and each and every subparagraph thereof.
2. Paragraphs B and B(1) through B(4).

THIRD SPECIFICATION PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct under N.Y. Education Law Sec. 6530(3) (McKinney Supp. 1997) in that he practiced the profession with negligence on more than one occasion as alleged in the facts of at least two of the following:

3. Paragraphs A, A(1) and each and every subparagraph thereof, through A(2) and each and every subparagraph thereof; and B and B(1) through B(4).

FOURTH AND FIFTH SPECIFICATIONS
PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct under N.Y. Education Law Sec. 6530(6) (McKinney Supp. 1997) in that he practiced with gross incompetence as alleged in the following facts:

4. Paragraphs A and A(1), and each and every subparagraph thereof, through A(2) and each and every subparagraph thereof.
5. Paragraphs B and B(1) through B(4).

SIXTH SPECIFICATION
PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct under N.Y. Education Law Sec. 6530(5) (McKinney Supp. 1997) in that he practiced the profession with incompetence on more than one occasion as alleged in the facts of at least two of the following:

6. Paragraphs A, A(1) and each and every subparagraph thereof, through A(2) and each and every subparagraphs thereof; B and B(4).

SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law Sec. 6530(20) (McKinney Supp. 1997) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitnes to practice as alleged in the facts of the following:

7. Paragraphs B and B(1) through B(4).

EIGHTH AND NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law Sec. 320 (McKinney Supp. 1997) 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 the following:

8. Paragraphs A and A(1), and each and every subparagraph thereof, through A(2) and each and every subparagraph thereof.
9. Paragraphs B and B(5).

DATED: October 22, 1997
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct