



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

August 22, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Dept. of Health
Room 2438 Corning Tower
Empire State Plaza
Albany, New York 12237

Terry R. Pickard, Esq.
Loretta R. Kilpatrick, Esq.
Byrne, Costello & Pickard, P.C.
800 MONY Tower 1
Syracuse, New York 13202-2721

Jerry Clausen, M.D.
7361 Dogwood Lane
Manlius, New York

RE: In the Matter of Jerry Clausen, M.D.

Effective Date: 08/29/95

Dear Ms. Fascia, Mr. Pickard, Ms. Kilpatrick and Dr. Clausen :

Enclosed please find the Determination and Order (No. 95-118) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

PLACED IN MAIL
AUG 22 1995

NEW YORK STATE DEPARTMENT OF HEALTH 19

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

A handwritten signature in cursive script that reads "Tyrone T. Butler".

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

**IN THE MATTER
OF
JERRY CLAUSEN, M.D.**

**ADMINISTRATIVE
REVIEW BOARD
DECISION AND
ORDER NUMBER
ARB NO. 95-**

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, and EDWARD C. SINNOTT, M.D.**¹ held deliberations on August 3, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) June 6, 1995 Determination finding Dr. Jerry Clausen (Respondent) guilty of professional misconduct. The Office of Professional Medical Conduct (Petitioner) requested the Review through a Notice which the Board received on June 20, 1995. James F. Horan served as Administrative Officer to the Review Board. Cindy M. Fascia, Esq. filed a brief for the Petitioner which the Review Board received on July 25 1995. Loretta Fitzpatrick, Esq. and Terry R. Pickard, Esq. filed a brief for the Respondent , which the Review Board received on July 24, 1995, and a response brief, which the Board received on August 2, 1995. The Respondent submitted a Motion to Dismiss the Petitioner's Notice of Review, which the Board received on July 11, 1995. The Board received the Petitioner's reply to that motion on July 25, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

¹Dr. Price did not participate in the August 3, 1995 deliberations.
Dr. Stewart recused himself from participating in this case.

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, a psychiatrist, with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, moral unfitness in the practice of medicine, breaching patient confidentiality and failing to maintain adequate records. The charges involved the Respondent's treatment for, and association with, one(1) patient, whom the record refers to as Patient A. The charge dealing with breaching patient confidentiality alleged that the Respondent had provided confidential information about Patient A to Patient A's husband and to a second patient, Patient B.

The Hearing Committee determined that the Respondent was guilty of practicing with negligence on more than one occasion, breaching patient confidentiality and maintaining inadequate records. The Committee did not sustain the charges that the Respondent had practiced with gross negligence, gross incompetence, incompetence on more than one occasion, and engaging in conduct that evidences moral unfitness.

The Committee found that the Respondent began treating Patient A for agoraphobia in June, 1987, and that by the summer of 1988, that Patient A had begun to fall in love with the Respondent. The Committee found that the Respondent violated patient confidentiality in 1990 by informing the husband of Patient A, that Patient A wanted to have an affair with the Respondent. The Committee found that this disclosure breached Patient A's confidentiality because the Respondent had learned the information during individual therapy sessions with Patient A. The Committee found further that the Respondent had violated patient confidentiality by discussing matters concerning Patient A with

Patient B, including information that Patient A had romantic feelings for the Respondent.

The Committee determined that the Respondent failed to maintain an adequate record for Patient A, based on their finding that the Respondent failed to adequately document the course of Patient A's treatment. The Committee accepted the testimony by the Petitioner's expert witness that described the Respondent's notes as chaotic and unintelligible. The Committee found that the Respondent's records would not assist a treating physician in reviewing patient history and would not be adequate or legible to a subsequent treating physician.

The Committee determined that the Respondent was guilty of negligence on more than one occasion for the way he handled Patient A's romantic interest in the Respondent. The Committee found that on one occasion, the Respondent had allowed the Patient to remain in physical contact with the Respondent inappropriately after the Patient had initiated the contact. The Committee found that the Respondent attended Patient A's therapy sessions with a social worker therapist improperly from August to December, 1990; that the Respondent continued to call Patient A at home for a year following the time that the Respondent referred Patient A to another therapist; and, that the Respondent did not act prudently when he made a visit to Patient A's home in June, 1991. The Committee found that between August, 1991 through January, 1993 the Respondent had weekly one-on-one meetings with Patient A at a Wendy's Restaurant. The Committee found that these meetings constituted negligence on the Respondent's part because the meetings contributed to Patient A's problem of separation and exacerbated her feelings of attachment to the Respondent. The Committee also found that the Respondent committed other acts of negligence during these meetings by presenting Patient A with a gift and telling Patient A that the Respondent loved her. The Committee found that these acts by the Respondent confused Patient A and encouraged her feelings for the Respondent. The Committee also found the Respondent negligent for presenting Patient A with a cassette tape of songs with a romantic theme. The Committee found that this act once again confused Patient A and demonstrated the Respondent's inability to make a proper decision about Patient A.

The Committee voted to suspend the Respondent's license for three years, stayed the suspension and placed the Respondent on three years probation. The Committee found that the Respondent's treatment with respect to Patient A's romantic feelings for the Respondent, Patient A's

transference, was negligent and harmful to the patient. The Committee felt that the Respondent's conduct perpetrated unnecessary and excessive interaction with Patient A through meetings, home visits, telephone calls, sitting in on sessions with other therapists and giving Patient A gifts. The Committee found that the Respondent failed to recognize boundary crossings and its repercussions for Patient A, her husband and their children. The Committee acknowledged that Patient A was a difficult patient and that the Respondent's conduct involved only one patient and that the Respondent was successful in treating the Patient's agoraphobia. Based on all these factors the Committee found that the Respondent's license should not be revoked, and that a stayed suspension with probation that includes continuing education and monitoring would be the appropriate sanction in this case.

REQUESTS FOR REVIEW

PETITIONER: The Petitioner seeks a review of both the Committee's Determination on the charges and the Penalty.

The Petitioner argues that the Respondent was guilty of gross negligence, because the Respondent committed multiple acts of negligence that amounted cumulatively to egregious conduct. The Respondent also argues that several of the negligent acts alone rise to the level of egregious conduct, such as the conduct at the Wendy's restaurant when the Respondent presented Patient A with a statue as a gift, when the Respondent told Patient A he loved her, and when the Respondent presented the Patient with the cassette tape.

As to the penalty, the Petitioner asks the Review Board to overturn the Committee's penalty because the Respondent's serious conduct, which harmed Patient A, requires a more severe sanction. The Petitioner contends that the Respondent does not understand the boundary violations in the practice of psychiatry, that he was unable or unwilling to deal appropriately or decisively with the situation with Patient A and that the Respondent violated patient confidentiality. The Petitioner argues that the Hearing Committee's penalty is inadequate in light of the Respondent's serious and protracted misconduct. The Petitioner notes that the Respondent's most egregious misconduct toward

Patient A took place outside the Respondent's office. The Petitioner asks that the Review Board revoke the Respondent's license, or in the alternative, that the Board impose a period of actual suspension of at least one year, order retraining and place the Respondent on a lengthy probation, which would include monitoring and psychiatric evaluation.

RESPONDENT: The Respondent has moved to dismiss the Petitioner's Notice of Review, because the Petitioner did not serve the Notice by Certified Mail. The Petitioner opposes the dismissal, contending that the Respondent has received actual Notice of the Review in a timely manner.

If the Board does proceed with the Review, the Respondent argues that the Respondent was denied due process because the Petitioner's Statement of Charges failed to state the substance of the Respondent's alleged misconduct. The Respondent contends that Petitioner asked the panel to adjudge the facts in context of sexual misconduct, although there was no written charge of sexual misconduct. The Respondent asks the Board to address that issue.

The Respondent alleges that there were errors by the Hearing Committee. The Respondent alleges that the Committee disregarded improperly the testimony from the Respondent's expert witness Dr. Robinson, in favor of the testimony by the Petitioner's expert, Dr. Kavey. The Respondent also contends that the Committee did not address the issue of when the therapy for Patient A ended. The Respondent contends that the treatment for Patient A ended on July 2, 1990 and that all subsequent conduct must be judged by a different standard.

The Respondent also alleges that the Hearing Committee's findings on the charges were incorrect. The Respondent contends that the Respondent's medical records were adequate and that Dr. Robinson's testimony supported a finding that the records were adequate. The Respondent contends that the Committee erred in its findings on breaching patient confidentiality because Patient A consented to the release of information to both Patient A's husband and to Patient B. The Respondent argues that the Respondent was not guilty of negligence on more than one occasion. The Respondent contends that the Committee's findings relate to events that occurred after the physician/patient relationship terminated and there was no longer a duty of care which the Respondent owed, that the record lacks an articulated standard on which to make a determination, that Dr. Robinson stated that the facts did not rise to a level of negligence when judged in a clinical context,

that Patient A never revealed to the Respondent that she was under the care of a subsequent treating psychiatrist, that the Respondent told Patient A repeatedly that he had no romantic feelings for Patient A and that the Hearing Committee's Determination was sensationalized by the introduction of the statue and the cassette tape. The Respondent also alleges that the Petitioner failed to prove the charges against the Respondent by a preponderance of the evidence.

The Respondent argues that the Committee's Determination was not consistent with its findings, and, therefore, is not sustainable.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted. The Determination below reflects the unanimous opinion of all three (3) members who participated in this case.

The Review Board denies the Respondent's motion to dismiss the Petitioner's Notice of Review. The Respondent clearly had notice of the Petitioner's request for a review. We also reject the Respondent's argument that the Respondent did not have adequate notice of charges against him. The Hearing Committee's extensive Determination demonstrates clearly that all of the findings against the Respondent were based on the charges appearing in the Statement of Charges (Petitioner's Exhibit 1).

The Review Board votes 3-0 to sustain the Hearing Committee's Determination that the Respondent was guilty of negligence on more than one (1) occasion, failing to maintain adequate records and breaching patient confidentiality. Further, we sustain the Committee's Determination that Respondent was not guilty of gross negligence. On the gross negligence charge, we find that the Respondent's conduct toward Patient A was not egregious, either as to any individual act or as to repeated instances of negligence combined.

We reject the Respondent's arguments that the Hearing Committee's Determination was affected by error. The Hearing Committee did not commit error because they found the Petitioner's expert, Dr. Kavey, to be more credible than the Respondent's expert, Dr. Robinson. Determining

witnesses' credibility is a basic function of the Hearing Committee as a trier of fact and we defer to the Hearing Committee's judgement. The Committee's Determination at pages 13-14 set out clearly and specifically the Committee's findings as to each witness' credibility. We also reject the Respondent's argument that the Committee erred when they failed to make a finding that the Respondent's treatment of Patient A terminated on July 2, 1990. The Hearing Committee made findings that the Respondent referred Patient A to a therapist, under the Respondent's supervision, that the Respondent attended therapy sessions with the therapist and Patient A on six (6) occasions, the last one December 11, 1990, and that the Respondent billed Blue Cross for services he provided on those six (6) dates.² We also reject the Respondent's contention that there was no articulated standard by which to judge the Respondent's actions after therapy did actually terminate. The Committee's findings on these actions cite to testimony by Dr. Kavey that support those findings. Finally, there was no prejudice to the Respondent because the Hearing Committee saw the statue and the cassette tape.

The Review Board finds that the evidence before the Committee, including the testimony of Dr. Kavey and Patient A, support the Committee's findings and conclusion and the findings and that the conclusions are consistent with the Determination that the Respondent was guilty of negligence on more than one (1) occasion, failing to maintain adequate records and breaching patient confidentiality.

The Review Board votes 3-0 to sustain the Hearing Committee's penalty that suspended the Respondent's license for three (3) years, stayed the suspension and placed the Respondent on probation, with probation terms that include retraining and monitoring. We will, however, make one (1) revision on the probation.

We find that the stayed suspension with probation is appropriate in this case and that the penalty is consistent with the Committee's findings and conclusions. The Respondent lost sight of his objective with Patient A and handled her transference and countertransference badly. It is appropriate that the Respondent receive continuing education on transference, countertransference and managing

²The findings appear at paragraphs 15-17 of the Hearing Committee's Determination, on pages 5-6.

a difficult patient. It is also appropriate that a monitor will review the Respondent's practice and records over a three (3) year period to assure that the Respondent's practice and records compare favorably to generally accepted medical standards.

We modify the Terms of Probation at paragraph 6, only for clarification. The third sentence of Paragraph 6 should now read:

"This monitoring physician shall review randomly selected medical records from each place of Dr. Clausen's practice and evaluate those records to assure that Dr. Clausen's medical care compares favorably with generally accepted standards of psychiatric practice."

The Board agrees with the Hearing Committee that revocation is not necessary to protect the public in this case. Patient A was a difficult patient and there was no indication that the Respondent had been guilty of such misconduct involving other patients.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **SUSTAINS** the Hearing Committee on Professional Medical Conduct's June 6, 1995 Determination finding Dr. Jerry Clausen guilty of professional misconduct.
2. The Review Board **SUSTAINS** the Hearing Committee's penalty in this case, except that:
3. The Review Board **MODIFIES** the sixth paragraph in the Conditions of Probation as provided for in our Determination.

ROBERT M. BRIBER

SUMNER SHAPIRO

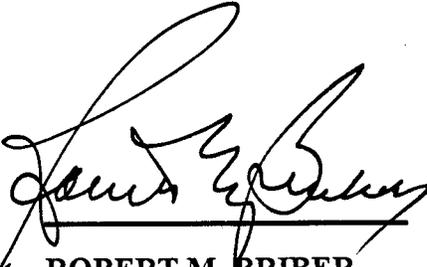
EDWARD SINNOTT, M.D.

IN THE MATTER OF JERRY CLAUSEN, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Clausen.

DATED: Albany, New York

Aug 16, 1995



ROBERT M. BRIBER

NEW YORK STATE JUDICIAL BRANCH

IN THE MATTER OF JERRY CLAUSEN, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Clausen.

DATED: Delmar, New York

August 16, 1995

A handwritten signature in cursive script, appearing to read "Sumner Shapiro", is written over a solid horizontal line.

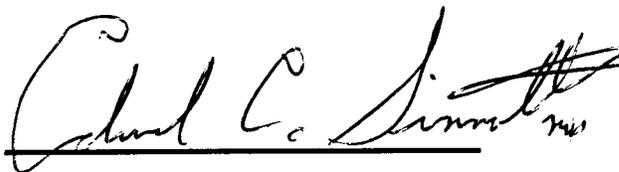
SUMNER SHAPIRO

IN THE MATTER OF JERRY CLAUSEN, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Clausen.

DATED: Roslyn, New York

Aug 16, 1995

A handwritten signature in cursive script, reading "Edward C. Sinnott, M.D.", written over a horizontal line. The signature is fluid and includes a large flourish at the end.

EDWARD C. SINNOTT, M.D.