From: Humbert, Jacob
To: [redacted]
Subject: RE: records request; re: Annette M. Lynch, M.D.
Date: Friday, May 6, 2022 1:34:01 PM
Attachments: LynchBMP(002)_Redacted.pdf

Dr. Lynch:

I am reaching out with an update related to your recent records request. To date, we have found no responsive records in our Montpelier offices. As for what Attorney General records may otherwise be stored off-site in the Vermont State Archives and Record Administration's Records Center in Waterbury, I will get back in touch with you as soon as I have confirmation as to whether any responsive records are still maintained there and, if so, (once any such records are recalled to our Office for review) whether any are open for public inspection or copying.

Nonetheless, please note we have acquired the attached .pdf from Board of Medical Practice ("BMP") staff during our efforts to identify the case you referenced in your request. This .pdf came to us with various patient names already redacted. Similarly, I have further redacted patient names not originally redacted in the .pdf (at pages 146-167 re: Patient L and daughter). *See* 1 V.S.A. § 317(c)(7) (exempts from public inspection or copying "[p]ersonal documents relating to an individual, including. . . information in any files relating to personal finances; medical or psychological facts concerning any individual"). You have a right to appeal my redaction decision to Office of the Attorney General's Chief of Staff, Charity Clark, pursuant to 1 V.S.A. § 318(c)(1).

In any event, again, should you wish to request records produced or acquired by the BMP related to this BMP case, please feel free to reach out the Department of Health as identified below or directly to the BMP itself.

Thank you.

Jacob A. Humbert, Assistant Attorney General
Director, Administrative Law Unit
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
(802) 828-0276
jacob.humbert@vermont.gov
Pronouns: he/him/his

From: Humbert, Jacob
Sent: Thursday, April 28, 2022 10:29 AM
To: [redacted]

Subject: records request; re: Annette M. Lynch, M.D.

Dr. Lynch:

Thank you for speaking with me and for clarifying the scope of your recent records request. I understand that you are seeking any and all records produced or acquired by the Office of the Attorney General related to a medical license enforcement case from the early- to mid-1990s, concerning Annette M. Lynch, M.D. I also understand that you are the Annette M. Lynch wo was the subject of such medical license enforcement case. My Office will search for any responsive records, which as I indicated likely will require reaching out the Vermont State Records Center to search for any remaining records in storage given the significant passage of time.

As we further discussed, you also wish to obtain records of the Vermont Board of Medical Practice ("BMP") concerning the same case. As my Office is not the custodian of any BMP records, I recommended that you reach out separately to the Vermont Department of Health Records Officer to submit a records request for BMP records. To that end, please note that such Records Officer's contact information is:

> Charon Goldwyn
> Health Department Operations & Records Officer
> AHS.VDHPublicRecordsRequests@vermont.gov

Thank you.

Jacob A. Humbert, Assistant Attorney General
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STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

Docket Nos. MPN10-0790
MPN71-0690
MPN37-0593
MPN68-0892
MPN69-0892
MPN55-0490
MPN67-0892
MPN15-1089

In re Annette M. Lynch, M.D. } Hearing held at
} Montpelier, Vermont
} June 17, 1996

HEARING PANEL DISCUSSION AND FINAL ORDER

On April 26, 1996, the Board hearing committee filed its report in this case. The parties subsequently filed requests for modification of the report. The hearing panel reviewed the parties' requests and the record and made some of the modifications requested by the parties and rejected other requested modifications. See Rulings on Requests to Modify Hearing Committee Report, dated May 31, 1996, and attached to this order.

A disposition hearing was held on June 17, 1996. At the hearing, respondent argued that the hearing committee's report was flawed because it found in paragraph 337 that respondent never ordered any blood tests for Patient K while prescribing lithium for her. Respondent's exhibit A175 does contain a record from the Rutland Regional Medical Center showing that the level of lithium in Patient K's blood was checked once, on January 29, 1993. Therefore, paragraph 337 of the committee report is modified to read:

"337. Despite prescribing these powerful drugs, respondent never performed a physical examination of Patient K. Respondent ordered and obtained only one lithium level for Patient K while prescribing lithium for her. This was inadequate. Blood testing is especially important when lithium is prescribed, because lithium toxicity is closely related to serum lithium levels and can occur at doses close to therapeutic levels."

This modification of paragraph 337 does not measurably improve the quality of care respondent rendered to Patient K, however. Respondent's exhibit A175 shows that she was still prescribing lithium for Patient K on February 26, 1993. Patient K's medical records do not show any additional tests for lithium blood levels other than the test on January 29, 1993. As paragraphs 234, 235, and 239 of the committee report indicate, a

prudent physician prescribing lithium should carefully monitor the level of the drug in the patient's blood throughout treatment. Testing once during the course of Patient K's treatment was not sufficient.

At the disposition hearing, respondent also argued that the hearing committee's report was flawed because it found in paragraph 338 that respondent never obtained an EKG for Patient K. Respondent's exhibit A175 does contain results of a cardiac (Holter) monitor reading for Patient K.

In view of the results of the Holter monitor shown in respondent's exhibit A175 and in view of the fact that a Holter monitor is a type of EKG, paragraph 338 of the committee report will be deleted, and paragraph 349 will be modified as follows to reflect the deletion of paragraph 338:

"349. She failed to provide adequate monitoring and follow-up for a patient taking, among other drugs, tricyclic antidepressants, lithium, and benzodiazepines. She obtained only one lithium blood level, despite the necessity of closely monitoring serum lithium levels, especially when initiating therapy."

Turning to a more general discussion of this case, the evidence shows overwhelmingly that respondent violated the standard of care on numerous occasions. She used poor judgment in caring for her patients, especially with respect to evaluation and monitoring of patients for whom she prescribed addictive or potentially toxic psycho-active medications. She put patients at risk by attempting to treat them in ways for which there was no adequate medical research or community support. And, as she made clear in her address to the hearing panel on June 17, respondent is unable or unwilling to recognize the deficiencies of her practice, even after those deficiencies have been identified for her. She blames the Board and its employees for the disciplinary predicament in which she finds herself. At this point, her prospects for rehabilitation must be assessed as poor.

It may be true, as respondent contends, that she has helped a number of people with serious mental illness and scant financial resources. However, as set forth above, she poses a danger to those patients and to others. The hearing panel must do what it can to remove that danger and to ensure that the public is adequately protected. The sole disposition that can achieve those objectives is license revocation, accompanied by conditions on reinstatement sufficient to ensure that the public will continue to be protected adequately if respondent ever returns to medical practice in this state.

Order

IT IS HEREBY ORDERED by the Board of Medical Practice of the State of Vermont that:

1. Count XIV of the amended specification of charges is DISMISSED.

2. The findings and conclusions of the hearing committee are ADOPTED WITH MODIFICATIONS, as set forth in the hearing panel's "Rulings on Requests to Modify Hearing Committee Report," dated May 31, 1996, and as set forth above in the hearing panel's discussion in this document.

3. On the basis of each of the Conclusions of Law A, B, C, D, E, F, G, H, I, J, K, L, M, and N, and not a combination of any or all of them, respondent's license to practice medicine in the State of Vermont is REVOKED.

4. The Board will consider an application from respondent for license reinstatement no sooner than five years from the effective date of this order. In addition to meeting all other requirements for license reinstatement, respondent must show the following:

(a) Successful completion of three years of post-graduate training in adult psychiatry in a residency program approved by the Accreditation Council for Graduate Medical Education.

(b) Successful completion of the mini-residency in "The Proper Prescribing of Controlled Dangerous Substances" at the Robert Wood Johnson Medical School of the University of New Jersey.

(c) Successful completion of a graduate-level course in psychopharmacology, approved by the Board in writing in advance of enrollment in the course.

(d) Successful completion of a graduate-level course in boundary issues in the practice of psychiatry, approved by the Board in writing in advance of enrollment in the course.

(e) Submission of a plan to the Board for its approval, for assessment of respondent's practice skills and personal health (including physical and mental health, with a component assessing likelihood of sexual misconduct with patients), such assessment to be at respondent's expense.

(f) Submission of the results of such Board-approved assessment to the Board for its review, as part of any reinstatement proceedings.

5. Successful completion of requirements (a) through (f)

above shall not result in automatic reinstatement of respondent's medical license. Respondent must apply for license reinstatement and meet all other Board requirements for reinstatement in addition to requirements (a) through (f) above.

6. If the Board reinstates respondent's medical license, she must successfully complete two successive years of supervised medical practice, approved in advance by the Board and immediately following license reinstatement.

7. Respondent shall bear all costs of compliance with this order.

8. Pursuant to 3 V.S.A. § 131(c)(2)(C), this document is a public record.

9. This order takes effect as of the date of entry shown below.

Appeal Rights

This is a final administrative determination. A party may appeal by filing a written notice of appeal with the Director of the Office of Professional Regulation, Office of the Secretary of State, within 30 days of the effective date of this order.

Dated: July 3, 1996

VERMONT BOARD OF MEDICAL PRACTICE

Charles C. Cunningham, M.D.
Hearing Panel Co-Chair

Priscilla B. Fox, J.D.
Hearing Panel Co-Chair

DeWees H. Brown, M.D.

Hon. Hilton H. Dier, Jr.

Elizabeth A. Turner, M.D., J.D.

Carol A. Vassar, M.D.

H. James Wallace, Jr. M.D.

Date of entry: July 3, 1996

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re Annette M. Lynch, M.D.	}	Docket Nos. MPN10-0790
	}	MPN71-0690
	}	MPN37-0593
	}	MPN68-0892
	}	MPN69-0892
	}	MPN55-0490
	}	MPN67-0892
	}	MPN15-1089

RULINGS ON REQUESTS TO MODIFY HEARING COMMITTEE REPORT

Petitioner and respondent filed requests to modify the hearing committee's report dated April 26, 1996. Petitioner also filed a request for oral argument on her objections and requests to modify the report. After review and consideration of the parties' filings, the hearing committee rules as follows.

1. Finding 37 of the report is DELETED.

2. Finding 38 of the report is DELETED.

3. Finding 48 of the report is DELETED.

4. Finding 49 of the report is DELETED.

5. Finding 137, second sentence, is MODIFIED to read: "During the course of her treatment by respondent, she was hospitalized five times, four of which were for depression or suicidal ideation." The rest of finding 137 remains unchanged.

6. Finding 345 is MODIFIED to read: "She failed to perform a complete and thorough evaluation of Patient K in connection with diagnosing and treating her with powerful drugs."

7. Finding 466 is MODIFIED to read: "After a time, respondent began touching Patient O softly and sensuously on his knees and thighs. She spoke quietly to him, telling him to let himself go. Patient O detached himself mentally from what was happening. He sensed that something was not right. This episode lasted approximately half an hour. Patient O felt demeaned by this episode."

8. Respondent's request for an evidentiary hearing and oral argument on admissibility of polygraph evidence is DENIED. See Entry Regarding Motion to Admit Polygraph Results dated May 24, 1996.

9. Respondent's request for oral argument on her objections

and requests to modify the hearing committee's report is DENIED. The written materials filed by the parties have provided the hearing panel with ample and sufficient explanation and information about the parties' respective requests for modification of the report.

10. Repondent's request to forward to the hearing panel the complete testimony of Nancy Coyne, M.D., is DENIED. The hearing panel already has the complete transcript of Dr. Coyne's August 11, 1995, testimony and all exhibits admitted in connection with her testimony.

11. Respondent's request to substitute new pages 10, 11, 37, 38, and 42 for the pages of the same number filed on May 20, 1996, is DENIED. The substitute pages were filed out of time, add little, if anything, to respondent's arguments, and would make her May 20 filing more difficult to read and understand because of text reconfiguration in the substitute document. In those instances in respondent's May 20 filing where she neglected to specify the modification requested, the hearing panel has already inferred that she was asking it to reject the finding or findings at issue.

12. Respondent's request that the hearing panel hear the testimony of Michael C. Vinton on the results of polygraph testing is DENIED. See Entry Regarding Motion to Admit Polygraph Results dated May 24, 1996.

13. Respondent's requests that the hearing panel hear her testimony on her medical care objectives, the testimony of Dr. Elia Vecchione on her diagnostic and therapeutic acumen, relationships with co-workers, conduct with patients, and character, and the testimony of Jay Corbett, Susan Atkinson, Jerry Snay, and Boyd Tracy are DENIED. Respondent had ample time in June, August, September, and October 1995 to present such testimony orally at the hearings or in written form after the hearings. For example, there was discussion at the August 7, 1995 hearing about petitioner deposing Dr. Vecchione and respondent calling him to testify before the hearing committee later that month. However, Dr. Vecchione's testimony was never offered orally or in writing, until now.

14. Respondent's requests to open the record to allow her to file pleadings from Rutland Family Court regarding [redacted] and to consider additional medical records relating to [redacted] are DENIED. These materials could have been offered on August 7 and 8, 1995, when [redacted] testified before the hearing committee. Respondent has not offered any substantial and convincing reason to explain why she did not present this evidence when the case was heard by the committee. [redacted] testifed during two days of hearings. Respondent had months of prehearing discovery in which to explore the dimensions of [redacted]

[redacted] testimony. She also had two months of additional time after the hearings in which to file any written testimony and exhibits she wished to present. She had ample time during those months to present the evidence she now offers.

15. Respondent's remaining requests for modification of findings are DENIED. The hearing panel has reviewed and considered each of respondent's requests and and has checked them against the record in this case. In the opinion of the panel, respondent's requested modifications are unwarranted and unsupported by the evidence.

Dated: May 31, 1996

BOARD OF MEDICAL PRACTICE

Priscilla B. Fox

Hearing Panel Co-Chair

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

IN RE: ANNETTE LYNCH, M.D.	Docket Nos. MPN 10-0790 MPN 71-0690 MPN 37-0593 MPN 68-0892 MPN 69-0892 MPN 55-0490 MPN 67-0892 MPN 15-1089

AMENDED

SPECIFICATION OF CHARGES

1. ANNETTE LYNCH, M.D., (Respondent), is a physician licensed to practice medicine in the State of Vermont under License No. 42-0007669, and was so licensed during the time the conduct set forth in this Specification of Charges allegedly occurred.

2. Jurisdiction vests in the Vermont Board of Medical Practice by virtue of Title 26, Chapter 23, Section 1311 et seq.; and through Title 3, Chapter 5, Section 121 et seq., of the Vermont Statutes Annotated.

3. Respondent maintains a practice in psychiatry at her office located at 170 Stratton Road, Rutland, Vermont.

4. Respondent does not hold admitting privileges at the Rutland Regional Medical Center or at any other hospital facility in the State of Vermont.

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5. SHEILA CONROY works in the office of Respondent and holds herself out as a "psychotherapist". Ms. Conroy holds a Masters of Arts degree in "Counseling Psychology" from Antioch University. Ms. Conroy, during these alleged charges, was not a licensed Psychologist, nor was she licensed under any of the other health professions regulated by the State of Vermont. Ms. Conroy is not licensed nor is she able, under federal or state law, to write or order prescriptions for patients.

6. While Respondent avers that she and Ms. Conroy have "independent practices", Respondent admits that she and Ms. Conroy "collaborate in working together clinically"; that she "supervises" Ms. Conroy's work; and that she also prescribes medications for Ms. Conroy's patients. Respondent further admits that because of this relationship, she is able to bill insurance companies, including Medicare and Medicaid, for Ms. Conroy's services.

COUNT I (Patient "A")

7. "A", a 34 year-old female, became Respondent's psychiatric patient in May of 1989, having been referred to her by the Vermont Department of Health.

8. In 1990, Respondent concluded that patient "A's" financial problems were a continuing source of anxiety. On May 24, 1990, Respondent took over patient "A's" financial affairs by opening a trustee checking account for her with the Vermont Federal Bank. Respondent named herself as trustee of

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the account and was its only authorized signatory. Respondent instructed the bank to imprint the checks to read "Annette Lynch Trustee for ["A"]", with Respondent's address appearing below the imprint.

9. Respondent wrote several checks on said account and otherwise took over "A's" financial affairs. *Respondent also bought personal items from "A" including a lamp, a coat and other articles.*

10. By taking over the management of patient "A's" financial affairs *and by purchasing personal items from "A"*, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting; failed to recognize detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; and created an inappropriate financial and psychological dependency relationship between the patient and herself.

11. In the course of treatment, Respondent would repeatedly engage in heated arguments with "A" over therapeutic issues and Respondent's management of "A's" trustee account. During these outbursts, Respondent would scream at patient "A" and use profanity, evidencing a loss of self-control.

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12. By her actions as alleged in Paragraphs 7 through 11, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, *she* failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT II (Patient "B")

13. "B", a 36 year-old female, became Respondent's psychiatric patient in January, 1989. "B" had a history of multiple admissions to the Human Services Unit at the Rutland Regional Medical Center, including one which commenced on March 30, 1989 and ended on April 17, 1989. Following that discharge, Respondent arranged for this patient to do (in Respondent's words) a "mix of maintenance, messenger and clerical work with the promise of working as a tutor should her progress warrant it." *This work included running personal errands for Respondent such as buying* her meals, buying *her makeup and eyeglasses.* In fact, patient "B" did become employed by Respondent in all of those capacities.

14. As an employee of Respondent, patient "B" routinely had access to files, records and confidential information about other patients.

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15. As an employee of Respondent, patient "B" at the direction of Respondent *was told to go obtain a prescription with her Medicaid card and return the prescription back to Respondent. "B" took her Medicaid card, bought the $30.00 worth of prescription drugs and returned them to Respondent. "B" does not know what Respondent did with the medication.*

16. By hiring a patient into a responsible position as an employee within her office, thereby blurring the distinction between doctor and patient, on one hand, employer and employee, on the other, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

17. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; created an inappropriate financial and psychological dependency relationship between the patient and herself; and disregarded patient confidentiality by exposing the patient/employee to the medical and pharmaceutical records of other patients.

18. In the course of treatment, Respondent would repeatedly engage in heated arguments with "B" over Respondent's failure to pay "B" in a timely fashion for services

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rendered or to reimburse "B" for the items purchased for Respondent by "B".

19. By her actions as alleged in Paragraphs 13 through 18, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT III (Patient "C")

20. "C", a 33 year-old female, became Respondent's psychiatric patient in 1989. Immediately after a hospitalization in June of 1989, Respondent offered "C" employment in her office, doing clerical work and acting as a "friendly visitor" to some of Respondent's older, home-bound patients. Respondent also told "C" that she would use her as a "social worker" because of "C's" intelligence and perceptiveness.

21. As an employee of Respondent, patient "C" routinely had access to files, records and confidential information about other patients.

22. By hiring a patient into a responsible position as an employee within her office, thereby blurring the distinction between doctor and patient, on one hand, and employer and

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employee, on the other, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

23. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; created an inappropriate financial and psychological dependency relationship between the patient and herself; and enabled a breach of confidentiality by exposing the patient/employee to the medical and pharmaceutical records of other patients.

24. Respondent requested that patient "C" act as a "friendly visitor" for other patients, a function which "C" performed in regard to patient "D", an 82 year-old female nursing home resident. (see Count V below).

25. Respondent encouraged patient "C" to bring patient "D" to "C's" home "temporarily, until we can find a more suitable place". "D" stayed in "C's" home for approximately two weeks. *During which time patient "C" had an extremely stressful time attempting to care for patient "D". Respondent became very critical of "C's" care of "D" and humiliated and degraded "C". "D" called the police to come get her out of "C's" home after only two weeks.*

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26. By interposing patient "C" into the management of other patient's care, Respondent evidenced complete disregard for the confidentiality, health, safety and welfare of both patient "C" and the patient receiving the medications and/or care. Respondent likewise displayed a lack of comprehension regarding the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

27. In the fall of 1989, Respondent facilitated the placement of her 15 year-old female patient, "E", a patient with severe emotional problems, in the home of patient "C" and her 4-year-old son, "F". (see Count IV below). Respondent told "C" that "E" would "be her patient". This placement lasted only a few days.

28. By interposing patient "C" into the management of another patient's care, Respondent evidences complete disregard for the confidentiality, health, safety and welfare of both patient "C" and the patient receiving the medications and/or care. Respondent shows a lack of comprehension regarding the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

29. In the course of treatment, Respondent would repeatedly engage in heated arguments with "C" over therapeutic issues. During these outbursts, Respondent would scream at patient "C" and use profanity, evidencing a loss of

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self-control. *On one occasion, Respondent slapped "C" across the face.*

30. By her actions as alleged in Paragraphs 20 through 29, Respondent committed unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT IV (Patient "E")

31. "E", a 15 year-old female was, at all times relevant hereto, Respondent's patient.

32. Respondent facilitated the placement of her patient "E" in an unsupervised household living arrangement with her patient "C". (See Count III above).

33. By placing "E", as part of her treatment plan, in the residential care of another patient, Respondent jeopardized the care rendered to both patients.

34. By this conduct, Respondent evidences a complete disregard for the confidentiality, health, safety and welfare of both patient "E" and the patient "C".

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35. On at least one occasion, while "E" was Respondent's patient, "E" stayed overnight for the weekend at Respondent's home. Respondent had told "E" she would pay her to mow her lawn

over the weekend. "E" mowed the lawn and Respondent never paid "E" for the work.

36. On March 23, 1993, "G", the patient's mother, petitioned the Rutland District Probate Court for guardianship over her daughter, "E". A Hearing on "G's" petition was held on May 19, 1993.

37. At the May 19, 1993 hearing, Respondent testified, in part, as follows:

> Judge: Doctor, what do you think is in the best interest of ["E"]?
>
> Doctor [Respondent]: In regard to the money matter, ["E"] and I had worked on this before and requested, she made a request to SSI that the payee of her SSI check be changed from her mother, and I had agreed to act as her payee for a limited period of time...That hasn't gone through yet.
>
> Judge: Would you agree to be the payee?
>
> Doctor: I would agree. That would not be inconsistent with what I'm doing...The only question I have is being ["E's"] Guardian and Therapist at the same time.

38. After the May 19, 1993 hearing, Respondent was appointed Guardian of her patient, "E". That guardianship was ultimately transferred to "E's" mother, "G" on June 23, 1993, at "E's" request.

39. By attempting to take over the management of patient "E's" personal and financial affairs, even before the granting of a guardianship; and then by subsequently accepting guardianship over her own patient, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of

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doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

40. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; and created an inappropriate financial and psychological dependency relationship between the patient and herself.

41. By her actions as alleged in Paragraphs 31 through 40, Respondent engaged in unprofessional conduct in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT V (Patient "D")

42. "D", an 82 year-old female, was a patient of Respondent at the Rutland Regional Medical Center from August 23, 1989 until November 4, 1989. She was admitted there because of unstable moods, with outbursts of anger, aggressive behavior and depression. The Respondent made a diagnosis of early dementia and possible bipolar disorder.

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43. During that hospital stay, and on two occasions (September 30-October 1; October 22-23) Respondent took "D" home with her for overnight stays. *Respondent had also taken "D" home overnight with her once before while "D" was at McKerley Nursing Home. On all occasions, "D's" family was not apprised beforehand of these "overnight visits".*

44. Following "D's" discharge from the hospital and while "D" was at a nursing home, Respondent arranged to have another of her patients ("C", see Count VI above) act as a "friendly visitor" for "D".

45. Respondent's actions, as above-described, constituted a violation of recognized professional boundaries and disregarded "D's" rights of confidentiality. In so doing, Respondent demonstrated a lack of comprehension of the complexities of the patient-therapist relationship.

46. By her actions, as alleged in paragraphs 42, 43 44 and 45, Respondent engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

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COUNT VI (Patient "H")

47. On April 26, 1993, "H" entered Fay's Drug in Rutland, Vermont and presented a prescription for 50 Percocet tablets written by Respondent. Percocet is a narcotic analgesic and a Schedule II controlled substance. The registered pharmacist on duty was Ms. Tammy DelBianco.

48. Pharmacist DelBianco knew "H" and was aware of "H's" prescription history at Fay's Drug. His most recent prescription from Respondent for 200 tablets of Percodan had been filled 20 days earlier, on April 5, 1993.

49. A review of "H's" prescription history at Fay's Drug Store alone reveals that from 8/4/92 to 12/24/92, a period of 143 days, "H" had received 1,010 tablets of Percocet or Percodan (also a Schedule II controlled substance) from Respondent. From 1/8/93 to 4/26/93, a period of 109 days, "H" had received 800 tablets of Percodan and 160 5 mg. tablets of Valium (a Schedule IV benzodiazepine) from Respondent.

50. Pharmacist DelBianco was also aware that "H" was seeing other physicians and receiving medications from them. In fact, Pharmacist DelBianco had, on that same day, filled a prescription for "H", issued by another physician, for 30 tablets of Darvocet-N-100, a Schedule IV controlled substance.

51. Concerned about this situation, Pharmacist DelBianco telephoned Respondent, an action fully commensurate with her ethical and professional obligations as a pharmacist.

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52. Pharmacist DelBianco spoke with Respondent and expressed her worry that "H" was receiving medication from other practitioners and might be abusing or diverting controlled substances. Respondent seemed surprised that "H" was seeing other practitioners. Respondent stated to Pharmacist Delbianco that "H" was receiving pain medication for a back problem.

53. Respondent admitted that she was also concerned that "H" was abusing or diverting medications, in part because "H" was a truck driver and "had the right connections".

54. Pharmacist DelBianco declined to fill "H's" prescription.

55. Three days later, on April 29, 1993, "H" entered Fay's Drug with two prescriptions written by Respondent, each dated 4/29/93; one for 150 tablets of Tylox (a Schedule II narcotic analgesic) and one for 100 tablets of Valium (a Schedule IV benzodiazepine). Considering her previous conversation with Respondent, and Respondent's agreement that "H" might be abusing or diverting medications, Pharmacist DelBianco was alarmed at the types and quantities of medications being sought by "H" under Respondent's prescriptions.

56. Pharmacist DelBianco called Respondent and expressed her surprise that "H" had again received prescriptions for scheduled drugs from Respondent. Pharmacist DelBianco wanted to know if Respondent had "checked out" the possible medication abuse and/or diversion issues with her patient or

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with the other prescribing doctors. Respondent replied that she had discussed those issues with the patient and was satisfied with his answers. Pharmacist DelBianco urged Respondent not to necessarily take the patient's word at face value, but to check with the other practitioners and pharmacies. Respondent became aggravated by Pharmacist DelBianco's questioning, and terminated the conversation.

57. Respondent did not check with other practitioners, despite being warned about the potential abuse and/or diversion of prescription medications by her patient, "H". Eighteen days later, on 5/18/93, Respondent wrote prescriptions for "H" for another 100 tablets of Tylox and 50 tablets of Valium.

58. Patient "H" was subsequently convicted of four counts of Obtaining Controlled Substance by Deception based on prescriptions written by Respondent and another physician.

59. A physician may only write a prescription in good faith and may not write any prescription outside the course of professional practice as set forth in 18 V.S.A. § 4214.

60. Based on the facts alleged in paragraphs 47 through 58, Respondent has prescribed drugs for other than legal or legitimate therapeutic purposes, which constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(6).

61. By her actions as alleged in Paragraphs 47 through 58, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use

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and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT VII (Patient "I")

62. In February of 1988, Respondent began treating three-year-old patient "I" (d/o/b 2/7/85), a child with an early history of abuse and neglect. Respondent diagnosed the child as suffering from a bipolar disorder and/or seasonal affect disorder. She treated the child with Tegretol, then Lithium and finally, by September of 1988, Respondent was prescribing Amitriptyline. During October of 1988, "I" was also prescribed Mellaril, an antipsychotic medication.

63. The use of any medication is necessarily predicated on a sound diagnosis derived by the application of established principles and protocols. The use of antipsychotic and antidepressant medication in young children may be undertaken only when a thorough evaluation and assessment of the patient, with careful regard given to differential diagnoses, leads the practitioner to a diagnosis which may justify their use. Then, treatment must proceed with extreme care, pursuant to a well-reasoned treatment plan which includes vigilant monitoring and follow-up. In difficult cases, such as the one presented

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by patient "I", consultations with experts are appropriate and expected as part of the treatment plan.

64. Respondent's management of "I's" case was deficient and substandard. Respondent failed to adequately evaluate patient "I" with the range of tools and protocols expected to be used prior to arriving at any diagnosis. Respondent failed to document her reasoning regarding "I's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent prescribed potent antipsychotic and antidepressant drugs based on an inconclusive foundation and then failed to provide adequate monitoring and follow-up. Respondent failed to obtain any consultations regarding the management of patient "I".

65. Respondent's management of "I's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

66. Alternatively, by repeatedly prescribing several potent anti-psychotic and antidepressant drugs to "I" under the conditions as described in Paragraphs 60, 61 and 62, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22)

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in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT VIII (Patient "J")

67. Patient "J" (d/o/b/ 8/20/89) was approximately 2 years, 9 months old when Sheila Conroy diagnosed and commenced treatment in May of 1992. Sheila Conroy, as stated in Paragraph 5 above, was not licensed as a health professional in the State of Vermont during the time period of these charges.

68. On June 12, 1992, Respondent wrote a prescription for Amitriptyline, 10 mg. for patient "J" at the request of Sheila Conroy. Respondent performed no physical or mental examination of "J" prior to providing this prescription for him, relying instead on the representations of Ms. Conroy and informal observations of the child during previous office visits of "J's" mother, "K", who was Respondent's patient. Based on this information, Respondent formed the belief that "J" was suffering from a major depression.

69. On June 19, 1992, "J" was seen by his family doctor, who had concerns that such a young child was being prescribed amitriptyline and that "J's" mother "cannot tell me the exact reason why". The doctor suggested to "J's" mother that she

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review "J's" medications with Respondent. The doctor also noted that he did not feel the child "has an active depression based on my interactions with him".

70. On or about June 30, 1992, Respondent increased the prescription to 25 mg. Amitriptyline for "J".

71. The use of any medication is necessarily predicated on a sound diagnosis derived by the application of established principles and protocols. The use of antipsychotic and antidepressant medication in young children may be undertaken only when a thorough evaluation and assessment of the patient, with careful regard given to differential diagnoses, leads the practitioner to a diagnosis which may justify their use. Then, treatment must proceed with extreme care, pursuant to a well-reasoned treatment plan which includes vigilant monitoring and follow-up.

72. It is mandatory that, prior to engaging in a treatment plan, the patient (or in the case of a minor child, his/her parent or guardian) is informed of the nature and character of the diagnosis, the range of potential treatments, the risks and benefits of potential treatments and the follow-up necessary to effectuate the treatment plan, and agrees to the treatment plan based on this information. This is characteristically called "informed consent".

73. Respondent's management of "J's" case was deficient and substandard. Respondent failed to adequately evaluate patient "J" with the range of tools and protocols expected to

be used prior to arriving at any diagnosis, relying instead on a few informal observations of "J" and the report of Sheila Conroy to base her diagnosis of a major depressive disorder. Respondent performed no direct physical exam of "J". Respondent failed to document her reasoning regarding "J's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent prescribed a potent antidepressant drug based on an inconclusive foundation and then failed to provide adequate monitoring and follow-up. Respondent failed to obtain *documented* informed consent from "J's" mother, "K".

74. Respondent's management of "J's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

75. Alternatively, by repeatedly prescribing a potent anti-psychotic and antidepressant drug to "J" under the conditions as described in Paragraphs 67 through 73, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful

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and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT IX (Patient "K")

76. Patient "K" (d/o/b/ 10/12/70) is the mother of patient "J" (see Count VIII above). According to Respondent, "K" first presented to, Sheila Conroy on May 11, 1992, "symptoms of depression, obsession, panic and paranoia". Sheila Conroy, as stated in Paragraph 5 above, is not licensed as a health professional in the State of Vermont.

77. Respondent maintained that patient "K" suffered from major depressive disorder, obsessive-compulsive disorder, and severe anxiety with panic, phobia, and "some psychotic features". Respondent characterized the patient's symptoms as "severe".

78. Despite the severe psychiatric problems presented by patient "K", Respondent allowed her to remain in the care of Sheila Conroy throughout the summer of 1992, seeing "K" only on two occasions, May 28, 1992 and June 26, 1992. Sheila Conroy saw patient "K" approximately 19 times through the end of July.

79. From May 28, 1992 through July 29, 1992, patient "K" received 21 prescriptions for medications. These medications included Perphenazine, Imipramine, Xanax, Anafranil, Klonopin, and Benzotropine. Respondent maintains that all prescriptions

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from her office are authorized by her. However, the record does not support that Respondent was consulted by Sheila Conroy prior to the prescribing of medications, nor does the record support that Respondent personally performed any examinations or conducted any evaluations of patient "K", other than possibly on May 27 and June 26, prior to the authorization of prescription medications.

80. Respondent maintained that patient "K's" mental state was improving over the course of the summer, but that she continued to exhibit symptoms of anxiety and "lesser degrees of depression and paranoia". During a visit on July 22 with Sheila Conroy, "K" expressed feeling like she was going to "explode"; that her heart was racing; that she was having anxiety attacks all day; that she couldn't think straight and couldn't remember anything; that she had paranoid thoughts and "feelings of doom". At a visit on July 29 with Sheila Conroy, "K" stated that she was feeling very angry, irritable and that she "blacks out" when she gets angry.

81. On or about August 4, 1992, patient "K" was admitted to Rutland Regional Medical Center because of a suicide attempt. Respondent characterized "K's" actions as "more of a gesture than a serious suicide effort".

82. It is mandatory that, prior to engaging in a treatment plan, the patient is informed of the nature and character of the diagnosis, the range of potential treatments, the risks and benefits of potential treatments and the follow-up necessary to

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effectuate the treatment plan, and then agrees to the treatment plan based on this information. This is characteristically called "informed consent".

83. Respondent's management of "K's" case was deficient and substandard. Respondent failed to adequately evaluate patient "K" with the range of tools and protocols expected to be used prior to arriving at any diagnosis. Respondent performed no direct physical exam of "K". Respondent failed to document her reasoning regarding "K's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent deferred management of "K's" case, characterized as "severe" by Respondent, to an unqualified caregiver, Sheila Conroy. Respondent allowed Sheila Conroy to adjust and prescribe potent psychotropic medications for "K" and/or Respondent prescribed such medications to "K" without personal examination or evaluation, based solely on the representations of Sheila Conroy. Respondent failed to provide adequate monitoring and follow-up. Respondent failed to obtain documented informed consent from "K".

84. Respondent's management of "K's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar

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practice under same or similar conditions, whether or not actual injury to a patient has occurred.

85. Alternatively, by repeatedly prescribing a combination of several potent drugs to "K" under the conditions as described in Paragraphs 76 through 83, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT X (Patient "L")

86. Respondent commenced diagnosis and treatment of patient "L", a 37 year-old woman, around March of 1990.

87. Over an approximately two year period, Respondent prescribed a variety of controlled and non-controlled medications to patient "L", including Methocarbamol, Amitriptyline, Perphenazine, Bentropine, Klonopin, Roxilox, Lorazepam, Diazepam, Perphenazine, Prozac, Trazodone, Kemadrin, Diphenhydramine, Cyclobenzaprine, Feldene, Xanax, Tylox, Chlorpromazine, and Anafranil.

88. According to Respondent, Patient "L" was also in treatment, at various times, for the disease of alcoholism.

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89. Respondent's use and management of pharmaceutical, especially the use of the benzodiazepine class of drugs over a protracted length of time in a patient with alcohol problems, constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XI (Patient "L")

90. Patient "L" has a documented history of cardiac problems. During a Friday evening appointment at Respondent's office in September of 1991, patient "L" complained of a racing heartbeat and chest pain. Respondent listened to "L's" heartbeat and told her that it was running at 200 beats per minute. Respondent dispensed 11 tablets of medication to "L", to be taken immediately in one dose. Eight of the tablets are believed by "L" to have been 5 mg. Diazepam tablets, and three of the tablets, yellow in color, were unknown to "L".

91. After 15 to 20 minutes, "L's" chest pain worsened and the rapid heartbeat had not abated. Respondent did not refer "L" to a cardiologist or suggest to "L" that she go to the hospital Emergency Room. Instead, Respondent ordered "L" to

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completely undress, put on a nightgown, and lay down on a convertible bed located in Respondent's office. Patient "L" did as she was told, and fell asleep on the bed.

92. Patient "L" awakened late on that Friday night to find Respondent in the bed beside her, with her arm draped over "L's" shoulder. "L" fell back to sleep.

93. Respondent lodged patient "L" in her office suite on Stratton Road throughout that weekend. From time to time during that weekend, "L's". care was entrusted to Respondent's friend, a person untrained in any health care profession. Respondent ordered that person to administer prescription medication to patient "L" in an amount and type similar to that dispensed by Respondent. Patient "L" awakened late on Saturday night to find the person in the bed beside her. "L" fell back to sleep.

94. By this conduct, Respondent evidenced a disregard for the confidentiality of "L's" health status and a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

95. In December of 1991, Respondent and Sheila Conroy, instructed patient "L" to lodge and care for "M", another of Respondent's patients. "M" stayed with "L" until spring, 1992. *The arrangement was deleterious for both patient "L" and patient "M", and for "L's" teenage daughter.*

96. By interposing patient "L" into the management of another patient's care, Respondent evidences complete disregard for the confidentiality, health, safety and welfare of both patient "L" and patient "M". Respondent exhibits an utter lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

97. By her actions as alleged in Paragraphs 90 through 96, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

98. Alternatively, by her actions as alleged in Paragraphs 90 through 96, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

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COUNT XII (Patient "L")

99. "L" was scheduled to appear pro se in Rutland Family Court on May 18, 1992 regarding highly contested issues of child custody. Respondent assured "L" that she would accompany "L" to the court proceeding and assist her. "L" relied on Respondent's representations.

100. On the day of the Court hearing, "L" met Respondent's patient/employee "N" on the steps of the Courthouse. "N" informed "L" that Respondent would not be able to accompany "L" to the Court due to illness, but that Respondent had sent "N" in her place.

101. Respondent had instructed patient/employee "N" to administer prescription medication to patient "L" before the hearing. The medication dispensed by patient/employee "N" to patient "L" was three tablets of 5 mg. Valium, a regulated drug, which "L" was instructed to take all at once. The administration of these drugs severely impaired "L's" ability to interact effectively with the Court, thereby jeopardizing both her legal position and her mental state.

102. Patient/employee "N" is not licensed as a nurse, intern, medical assistant or resident by the State of Vermont, nor is "N" a member of "L's" family. "N" is not authorized by law to dispense medications on behalf of Respondent.

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103. In her interaction with "N" at the Family Court, it became obvious to "L" that Respondent's patient/employee "N" was fully aware of minute details of confidences shared by

"L" with the Respondent during the course of therapy and within the therapeutic environment, evidencing a breach of confidentiality by Respondent and/or Sheila Conroy.

104. After the Family Court Hearing, "L" learned that Respondent was actually in her office and was not ill. "L" went back to Respondent's office to confront Respondent regarding the breach of confidentiality with patient/employee "N", and the failure to Respondent to accompany her to the Court proceeding as she had promised.

105. Respondent told "L" that she had not gone to the Court proceeding with "L" because "you ["L"] are not going to make a damn fool out of me".

106. "L" told Respondent that any further breaches of confidentiality would result in a lawsuit. Respondent then physically assaulted patient "L", placing "L" in fear for her personal safety.

107. Respondent physically shook patient "L" on at least two other occasions, without provocation, in the course of treatment, Respondent would berate, scream at and belittle patient "L", using loud, heated and profane language, evidencing a loss of control. *One time Respondent did this in the presence of "L's" teenage daughter.*

108. By her actions as alleged in Paragraphs 99 through 107, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion

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that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under similar conditions.

109. Alternatively, by her actions as alleged in Paragraphs 99 through 107, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XIII (Patient "O")

A.

110. In November of 1989, Respondent began prescribing methadone for patient "O", a 37 year-old male with severe drug dependency problems. Respondent prescribed methadone to "O" for the purpose of treating his opiate addiction, controlling the pain and gradually bringing the dose of methadone down to a therapeutic level.

111. Respondent admits that said prescriptions were given for the purpose of replacing the opiates abused by "O" but also claims that the methadone was prescribed to control chronic back pain. However, the primary effect of the prescriptions was the treatment of a narcotic addiction.

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112. "O", although suffering from some back pain, did not consult with Respondent for purposes of management of chronic back pain, but rather sought her services for treatment of his depression.

113. Respondent prescribed methadone as well as other potent narcotic analgesics for "O", with full knowledge and understanding that she was attempting to undertake an opiate maintenance program. Respondent continued to prescribe large amounts of methadone and other narcotic analgesics for opiate maintenance, fraudulently justifying them as treatment for "O's" chronic back pain.

114. Methadone is a Schedule II narcotic prescription drug with a high potential for abuse and addiction. Methadone is used, under strictly controlled conditions, in maintenance treatment and detoxification treatment for people addicted to illegal opiates.

115. Methadone, as a powerful narcotic analgesic, may be used for the relief of severe pain, it must be used with extreme caution due to its addictive potential. Respondent's use of it in "O's" case was inappropriate.

116. The use of methadone or any narcotic drug for the purpose of maintenance treatment or detoxification treatment of drug addiction is strictly regulated by federal law, and may not be legally undertaken without the appropriate federal licenses and certifications.

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117. In accordance with the standards set forth in 21 U.S.C. Sec.823(g), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose.

118. Respondent did not have the federally required registration to dispense narcotic drugs for maintenance or detoxification treatment during her treatment of "O", and, therefore, was in violation of federal law.

119. In addition, the Code of Federal Regulations sets forth the "appropriate methods of professional practice" concerning the use of narcotic drugs for maintenance treatment or detoxification treatment of narcotic addicts. 21 C.F.R. §§ 291.501 and 291.505.

120. In her methadone maintenance of "O", Respondent violated the requirements for methadone maintenance treatment of narcotic addicts established in 21 C.F.R. §§ 291.501 and 291.505 as detailed below.

121. Respondent did not obtain the approval of the necessary governmental authorities before prescribing, administering, or dispensing methadone for her treatment of "O" as required by 21 C.F.R. § 291.505(b)(2)(iv).

122. Before treating "O" with methadone, Respondent did not determine whether "O" met the minimum standards for treatment as required by 21 C.F.R. § 291.505(d)(1)(i)(A) and (B), and did not record in "O's" record the criteria used to

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determine "O's" physiologic dependence and history of addiction as required by § 291.505(d)(1)(i)(C).

123. Before treating "O" with methadone, Respondent did not obtain "informed consent" from "O"; she did not ensure that all relevant facts concerning the use of methadone were explained to "O" as required by 21 C.F.R. § 505(d)(1)(ii).

124. Respondent did not complete an initial drug-screening test or analysis for "O" and did not perform additional random tests or analyses during her treatment of "O" as required by 21 C.F.R. § 291.505(d)(2)(i).

125. Respondent did not perform the minimum medical evaluation of "O" as required by 21 C.F.R. § 291.505(d)(3)(i) and did not record the findings of such evaluation as required by § 291.505(d)(3)(ii).

126. Prior to treating "O" with methadone, Respondent did not have "O" interviewed by a well-trained drug treatment program counselor to determine the appropriate treatment plan for "O", as required by 21 C.F.R. § 291.505(d)(3)(iii).

127. Respondent did not establish a treatment plan as required by § 291.505(d)(3)(iv).

128. Respondent did not complete a periodic treatment plan evaluation for "O" and did not ensure that such plan became a part of "O's" record as required by 21 C.F.R. §291.505(d)(3)(v). Respondent started "O" on 60 milligrams of methadone a day on 11/7/89, thereby failing to ensure that the initial dose of methadone did not exceed 30 milligrams and that the total dose

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for the first day did not exceed 40 milligrams as required 21 C.F.R. § 291.505(d)(6)(i)(A).

129. Before giving "O" take-home methadone, Respondent did not determine whether "O" would be responsible in handling narcotic drugs according to the standards set forth in 21 C.F.R. § 291.505(d)(6)(iv)(B), and did not record any such determination in "O's" record, all of which is required by 21 C.F.R. § 291.505(d)(6)(iv)(A).

130. Respondent did not observe "O" on a daily basis or 6 days a week during the course of his methadone treatment, did not follow the criteria for reducing that frequency, and did not limit the take-home methadone to a 2-day supply as required by 21 C.F.R. § 291.505(d)(6)(v)(A)(1). Further, none of the exceptions from the take-home requirements listed in § 291.505 (d)(6)(vi) is applicable and, in any event, Respondent did not record a rationale for an exception in the patient's record as required by that subdivision.

131. Short term detoxification treatment is regulated by 21 C.F.R. § 291.505(d)(8) and is defined in the portion of (a)(1)(i) as follows:

> Short-term detoxification treatment is for a period not in excess of 30 days.

132. To the extent that Respondent considered her treatment of this patient to be short-term detoxification rather than drug maintenance, she violated several of the standards set forth in 21 C.F.R. § 291.505(d)(8).

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133. Respondent did not administer methadone to "O" daily, under close observation, in reducing dosages over a period not to exceed 30 days as required by 21 C.F.R. § 291.505(d)(8)(i).

134. Respondent gave "O" take-home medication in violation of 21 C.F.R. § 291.505(d)(8)(i)(A).

135. Respondent did not perform an initial drug screening test as required by 21 C.F.R. § 291.505(d)(8)(i)(D).

136. Long-term detoxification treatment is regulated by 21 C.F.R. § 291.505(d)(9) and is defined in the portion of (a)(1)(ii) as: "Long-term detoxification treatment is for a period more than 30 days but not in excess of 180 days".

137. To the extent that Respondent considered her treatment of this patient to be long-term detoxification rather than short-term detoxification or drug maintenance, she violated several of the standards set forth in 21 C.F.R. § 291.505(d)(9).

138. Respondent did not observe "O" while he ingested methadone daily or at least 6 days a week for the duration of his long-term detoxification treatment as required by 21 C.F.R. § 291.505(d)(9)(A).

139. Respondent did not document in "O's" record that short-term detoxification was not a sufficiently long enough treatment course before "O" began long-term detoxification as required by 21 C.F.R. § 291.505(d)(9)(C).

140. Respondent did not perform an initial drug screening test or analysis and did not perform at least one additional

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random test or analysis on "O" monthly during his long-term detoxification as required by 21 C.F.R. § 291.505(d)(9)(E).

141. Respondent did not prepare the required periodic treatment plan evaluation on "O" monthly as required by 21 C.F.R. § 291.505(d)(9)(F).

B.

142. During the summer of 1990, Respondent obtained controlled and non-controlled prescription drugs for dispensing and administering in her office by writing prescriptions for a patient, "O", who was then specifically instructed to fill the prescriptions and then return them to her. These medications were then re-dispensed to patients other than those for whom the original prescriptions were written.

143. This conduct contravenes 18 V.S.A. § 4214, which sets forth the professional use of regulated drugs; and 21 U.S.C. § 829, which sets forth prescriptions requirements. Such conduct also compromises the safety of drug products by contamination or adulteration, and jeopardizes patient care and protection.

144. By these actions, Respondent has failed to comply with the record-keeping, inventory and reporting requirements set forth in 18 U.S.C. §§ 827 and 828, in 21 C.F.R. §§ 1304 and 1305, and in 18 V.S.A. § 4210.

145. Such conduct discourages the accurate accounting of drugs dispensed by Respondent and received by her patients, and results in lessened scrutiny of her use of pharmaceuticals.

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146. By engaging patients in a scheme to procure prescription drugs for use in her office contrary to state and federal law, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting and failed to recognize detrimental effects that a breach of those boundaries might have on the patient, thus seriously compromising patient care.

C.

147. 18 V.S.A. Sec. 4217 states as follows:

> It shall be the duty of every physician and every hospital to report to the board of health, promptly, all cases wherein a person has been or is being treated for the use of, or for problems arising from the use of, regulated drugs. Said reports shall include the type of problem being treated, the class of regulated drug which was used and such further information as is required by regulation of the board of health as promulgated under section 4202 of this title, except that the regulations shall not require the listing or other identification of the names of the persons being so treated.

148. Respondent has failed to file any reports with the Vermont Department of Health regarding her detoxification and/or maintenance treatment of this patient.

D.

149. At Respondent's request, patient "O" sat in during initial sessions with at least one other set of patients, a couple who were attempting to undergo a opiate detoxification and maintenance program. During these sessions, at which both the other patients and Respondent were present, patient "O"

was consulted by Respondent and patient "O" suggested various avenues, including specific drug regimens, which might be implemented for detoxification and maintenance treatment. During these sessions, patients disclosed confidential information regarding their lives and their addiction to both Respondent and patient "O".

150. By interposing patient "O" into the management of other patient's care, Respondent evidenced complete disregard for the confidentiality, health, safety and welfare of both patient "O" and the other patient(s). Respondent showed a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

E.

151. Ostensibly to confront gender identity issues in patient "O's" life stemming from a physically and emotionally abusive childhood, Respondent instructed patient "O", on at least four separate occasions, to cross-dress and come to her office. These sessions took place late in the evening at Respondent's office on Stratton Road, after normal office hours.

152. During these sessions, Respondent would caress patient "O" on the face, neck, arms and thighs, and have him "pose" in various positions in an attempt to have him portray himself as a female. Respondent would encourage "O" to caress her arms. These sessions with Respondent were not an attempt at therapy but were sexually exploitative and demeaning.

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153. In the course of treatment, Respondent would repeatedly engage in heated arguments with "O" over therapeutic issues. During these outbursts, Respondent would scream at patient "O", using loud, heated and profane language, evidencing a loss of control.

154. The conduct alleged in Paragraphs 110 through 142 *indicate that* Respondent has prescribed drugs for other than legal and legitimate therapeutic purposes. 26 V.S.A. § 1354(6).

155. The conduct alleged in Paragraph 147 and 148 constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(9), in that Respondent willfully omitted to file or record medical reports required by law.

156. By her actions as alleged in Paragraphs 110 through 153, Respondent has engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

157. Alternatively, by her actions as alleged in Paragraphs 110 through 153, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent

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physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XIV

158. With reference to the above-alleged conduct, when considered in combination, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that she has failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

WHEREFORE, Respondent should be reprimanded or her license made subject to conditions, limits, suspension, or revocation, as the Board deems appropriate under the circumstances.

DATED: June 12, 1995

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

by: Sally S. Hackett
Sally Hackett, Secretary

Office of the
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Montpelier,
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STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In Re: Annette Lynch, MD	]	Docket Nos: MPN10-0790, MPN71-0690 MPN37-0593, MPN68-0892 MPN69-0892, MPN55-0490 MPN67-0892, MPN15-1089

NOTICE OF PREHEARING CONFERENCE AND NOTICE OF HEARING

Notice of Prehearing Conference

Please take notice that pursuant to 3 V.S.A. Section 129(g)(2), a prehearing conference will be held in the above-referenced matter on August 19, 1994, at 9:30 a.m., in the Office of the Assistant General Counsel, first floor, Redstone Building, 26 Terrace Street, Montpelier, Vermont. Any party wishing to participate by telephone must notify the Board at 828.2674 no later than 24 hours prior to the prehearing conference.

Notice of Hearing

Please take notice that pursuant to the authority vested in the State of Vermont Board of Medical Practice by Title 26, Chapters 7, 23, and 31, and by Title 3, Chapters 5 and 25, a hearing will be held before the Vermont Board of Medical Practice as scheduled at the above-noticed prehearing conference. The hearing shall continue from time to time as necessary. This hearing shall be held to consider whether the Vermont Board of Medical Practice should take disciplinary action against Annette Lynch, M.D., for alleged violations of Title 26, Chapter 7, 23, or 31, and Title 3, Chapter 5, as applicable. Said alleged violations are set forth in the attached Specification of Charges.

Said respondent shall have the opportunity to appear personally and to have counsel present, to present witnesses, evidence, and arguments on his or her own behalf, to cross-examine witnesses testifying against him or her, and to examine such documentary evidence as may be produced against him or her. Said respondent may file with the Board a written response to the Specification of Charges within 20 days of the date of service. A record of the proceeding will be kept.

All correspondence and documents pertaining to this matter should be filed with the Vermont Board of Medical Practice, 109 State Street, Montpelier Vermont 05609-1106, and

with the Chief of the Civil Division, Office of Attorney General, 109 State Street, Montpelier, Vermont 05609.

Date: July 6, 1994

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

by: Sally S. Hackett

Sally Hackett
Secretary of the Board

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

IN RE: ANNETTE LYNCH, M.D.	Docket Nos., MPN 10-0790 MPN 71-0690 MPN 37-0593 MPN 68-0892 MPN 69-0892 MPN 55-0490 MPN 67-0892 MPN 15-1089

SPECIFICATION OF CHARGES

1. ANNETTE LYNCH, M.D., (Respondent), is a physician licensed to practice medicine in the State of Vermont under License No. 42-0007669, and was so licensed during the time the conduct set forth in this Specification of Charges allegedly occurred.

2. Jurisdiction vests in the Vermont Board of Medical Practice by virtue of Title 26, Chapter 23, Section 1311 et seq.; and through Title 3, Chapter 5, Section 121 et seq., of the Vermont Statutes Annotated.

3. Respondent maintains a practice in psychiatry at her office located at 170 Stratton Road, Rutland, Vermont.

4. Respondent does not hold admitting privileges at the Rutland Regional Medical Center or at any other hospital facility in the State of Vermont.

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5. SHEILA CONROY works in the office of Respondent and holds herself out as a "psychotherapist". Ms. Conroy holds a Masters of Arts degree in "Counseling Psychology" from Antioch University. Ms. Conroy, during these alleged charges, was not a licensed Psychologist, nor was she licensed under any of the other health professions regulated by the State of Vermont. Ms. Conroy is not licensed nor is she able, under federal or state law, to write or order prescriptions for patients.

6. While Respondent avers that she and Ms. Conroy have "independent practices", Respondent admits that she and Ms. Conroy "collaborate in working together clinically"; that she "supervises" Ms. Conroy's work; and that she also prescribes medications for Ms. Conroy's patients. Respondent further admits that because of this relationship, she is able to bill insurance companies, including Medicare and Medicaid, for Ms. Conroy's services.

COUNT I (Patient "A")

7. "A", a 34 year-old female, became Respondent's psychiatric patient in May of 1989, having been referred to her by the Vermont Department of Health.

8. In 1990, Respondent concluded that patient "A's" financial problems were a continuing source of anxiety. On May 24, 1990, Respondent took over patient "A's" financial affairs by opening a trustee checking account for her with the Vermont Federal Bank. Respondent named herself as trustee of

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the account and was its only authorized signatory. Respondent instructed the bank to imprint the checks to read "Annette Lynch Trustee for ["A"]", with Respondent's address appearing below the imprint.

9. Respondent wrote several checks on said account and otherwise took over "A's" financial affairs.

10. By taking over the management of patient "A's" financial affairs, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting; failed to recognize detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; and created an inappropriate financial and psychological dependency relationship between the patient and herself.

11. In the course of treatment, Respondent would repeatedly engage in heated arguments with "A" over therapeutic issues and Respondent's management of "A's" trustee account. During these outbursts, Respondent would scream at patient "A" and use profanity, evidencing a loss of self-control.

12. By her actions as alleged in Paragraphs 7 through 11, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice failed

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to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT II (Patient "B")

13. "B", a 36 year-old female, became Respondent's psychiatric patient in January, 1989. "B" had a history of multiple admissions to the Human Services Unit at the Rutland Regional Medical Center, including one which commenced on March 30, 1989 and ended on April 17, 1989. Following that discharge, Respondent arranged for this patient to do (in Respondent's words) a "mix of maintenance, messenger and clerical work with the promise of working as a tutor should her progress warrant it." In fact, patient "B" did become employed by Respondent in all of those capacities.

14. As an employee of Respondent, patient "B" routinely had access to files, records and confidential information about other patients.

15. As an employee of Respondent, one of patient "B's" duties, acknowledged by Respondent, was to telephone prescriptions to area pharmacies on behalf of other patients, at the direction of Respondent and/or her office associate, Sheila Conroy.

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16. By hiring a patient into a responsible position as an employee within her office, thereby blurring the distinction between doctor and patient, on one hand, employer and employee, on the other, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

17. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; created an inappropriate financial and psychological dependency relationship between the patient and herself; and disregarded patient confidentiality by exposing the patient/employee to the medical and pharmaceutical records of other patients.

18. In the course of treatment, Respondent would repeatedly engage in heated arguments with "B" over therapeutic issues and Respondent's failure to pay "B" in a timely fashion for services rendered. During these outbursts, Respondent would scream at patient "B" and use profanity, evidencing a loss of self-control.

19. By her actions as alleged in Paragraphs 13 through 18, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree

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of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT III (Patient "C")

20. "C", a 33 year-old female, became Respondent's psychiatric patient in 1989. Immediately after a hospitalization in June of 1989, Respondent offered "C" employment in her office, doing clerical work and acting as a "friendly visitor" to some of Respondent's older, home-bound patients. Respondent also told "C" that she would use her as a "social worker" because of "C's" intelligence and perceptiveness.

21. As an employee of Respondent, patient "C" routinely had access to files, records and confidential information about other patients.

22. By hiring a patient into a responsible position as an employee within her office, thereby blurring the distinction between doctor and patient, on one hand, and employer and employee, on the other, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

23. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might

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have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; created an inappropriate financial and psychological dependency relationship between the patient and herself; and enabled a breach of confidentiality by exposing the patient/employee to the medical and pharmaceutical records of other patients.

24. Respondent requested that patient "C" act as a "friendly visitor" for other patients, a function which "C" performed in regard to patient "D", an 82 year-old female nursing home resident. (see Count V below).

25. Respondent encouraged patient "C" to bring patient "D" to "C's" home "temporarily, until we can find a more suitable place". "D" stayed in "C's" home for approximately two weeks.

26. By interposing patient "C" into the management of other patient's care, Respondent evidenced complete disregard for the confidentiality, health, safety and welfare of both patient "C" and the patient receiving the medications and/or care. Respondent likewise displayed a lack of comprehension regarding the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

27. In the fall of 1989, Respondent facilitated the placement of her 15 year-old female patient, "E", a patient

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with severe emotional problems, in the home of patient "C" and her 4-year-old son, "F". (see Count IV below). Respondent told "C" that "E" would "be her patient". This placement lasted only a few days.

28. By interposing patient "C" into the management of another patient's care, Respondent evidences complete disregard for the confidentiality, health, safety and welfare of both patient "C" and the patient receiving the medications and/or care. Respondent shows a lack of comprehension regarding the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

29. In the course of treatment, Respondent would repeatedly engage in heated arguments with "C" over therapeutic issues. During these outbursts, Respondent would scream at patient "C" and use profanity, evidencing a loss of self-control.

30. By her actions as alleged in Paragraphs 20 through 29, Respondent committed unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

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COUNT IV (Patient "E")

31. "E", a 15 year-old female was, at all times relevant hereto, Respondent's patient.

32. Respondent facilitated the placement of her patient "E" in an unsupervised household living arrangement with her patient "C". (See Count III above).

33. By placing "E", as part of her treatment plan, in the residential care of another patient, Respondent jeopardized the care rendered to both patients.

34. By this conduct, Respondent evidences a complete disregard for the confidentiality, health, safety and welfare of both patient "E" and the patient "C".

35. On March 23, 1993, "G", the patient's mother, petitioned the Rutland District Probate Court for guardianship over her daughter, "E". A Hearing on "G's" petition was held on May 19, 1993.

36. At the May 19, 1993 hearing, Respondent testified, in part, as follows:

> Judge: Doctor, what do you think is in the best interest of ["E"]?
>
> Doctor [Respondent]: In regard to the money matter, ["E"] and I had worked on this before and requested, she made a request to SSI that the payee of her SSI check be changed from her mother, and I had agreed to act as her payee for a limited period of time...That hasn't gone through yet.
>
> Judge: Would you agree to be the payee?

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Doctor: I would agree. That would not be inconsistent with what I'm doing...The only question I have is being ["E's"] Guardian and Therapist at the same time.

37. After the May 19, 1993 hearing, Respondent was appointed Guardian of her patient, "E". That guardianship was ultimately transferred to "E's" mother, "G" on June 23, 1993, at "E's" request.

38. By attempting to take over the management of patient "E's" personal and financial affairs, even before the granting of a guardianship; and then by subsequently accepting guardianship over her own patient, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

39. Respondent further failed to recognize the detrimental effects that a breach of those boundaries might have on the patient; failed to appreciate the phenomena of transference and counter-transference and their effects upon the doctor-patient relationship; and created an inappropriate financial and psychological dependency relationship between the patient and herself.

40. By her actions as alleged in Paragraphs 31 through 39, Respondent engaged in unprofessional conduct in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful

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and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT V (Patient "D")

41. "D", an 82 year-old female, was a patient of Respondent at the Rutland Regional Medical Center from August 23, 1989 until November 4, 1989. She was admitted there because of unstable moods, with outbursts of anger, aggressive behavior and depression. The Respondent made a diagnosis of early dementia and possible bipolar disorder.

42. During that hospital stay, and on two occasions (September 30-October 1; October 22-23) Respondent took "D" home with her for overnight stays.

43. Following "D's" discharge from the hospital and while "D" was at a nursing home, Respondent arranged to have another of her patients ("C", see Count VI above) act as a "friendly visitor" for "D".

44. Respondent's actions, as above-described, constituted a violation of recognized professional boundaries and disregarded "D's" rights of confidentiality. In so doing, Respondent demonstrated a lack of comprehension of the complexities of the patient-therapist relationship.

45. By her actions, as alleged in paragraphs 41, 42, 43 and 44, Respondent engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she

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failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT VI (Patient "H")

46. On April 26, 1993, "H" entered Fay's Drug in Rutland, Vermont and presented a prescription for 50 Percocet tablets written by Respondent. Percocet is a narcotic analgesic and a Schedule II controlled substance. The registered pharmacist on duty was Ms. Tammy DelBianco.

47. Pharmacist DelBianco knew "H" and was aware of "H's" prescription history at Fay's Drug. His most recent prescription from Respondent for 200 tablets of Percodan had been filled 20 days earlier, on April 5, 1994.

48. A review of "H's" prescription history at Fay's Drug Store alone reveals that from 8/4/92 to 12/24/92, a period of 143 days, "H" had received 1,010 tablets of Percocet or Percodan (also a Schedule II controlled substance) from Respondent. From 1/8/93 to 4/26/93, a period of 109 days, "H" had received 800 tablets of Percodan and 160 5 mg. tablets of Valium (a Schedule IV benzodiazepine) from Respondent.

49. Pharmacist DelBianco was also aware that "H" was seeing other physicians and receiving medications from them. In fact, Pharmacist DelBianco had, on that same day, filled

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a prescription for "H", issued by another physician, for 30 tablets of Darvocet-N-100, a Schedule IV controlled substance.

50. Concerned about this situation, Pharmacist DelBianco telephoned Respondent, an action fully commensurate with her ethical and professional obligations as a pharmacist.

51. Pharmacist DelBianco spoke with Respondent and expressed her worry that "H" was receiving medication from other practitioners and might be abusing or diverting controlled substances. Respondent seemed surprised that "H" was seeing other practitioners. Respondent stated to Pharmacist Delbianco that "H" was receiving pain medication for a back problem.

52. Respondent admitted that she was also concerned that "H" was abusing or diverting medications, in part because "H" was a truck driver and "had the right connections".

53. Pharmacist DelBianco declined to fill "H's" prescription.

54. Three days later, on April 29, 1993, "H" entered Fay's Drug with two prescriptions written by Respondent, each dated 4/29/93; one for 150 tablets of Tylox (a Schedule II narcotic analgesic) and one for 100 tablets of Valium (a Schedule IV benzodiazepine). Considering her previous conversation with Respondent, and Respondent's agreement that "H" might be abusing or diverting medications, Pharmacist DelBianco was alarmed at the types and quantities of medications being sought by "H" under Respondent's prescriptions.

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55. Pharmacist DelBianco called Respondent and expressed her surprise that "H" had again received prescriptions for scheduled drugs from Respondent. Pharmacist DelBianco wanted to know if Respondent had "checked out" the possible medication abuse and/or diversion issues with her patient or with the other prescribing doctors. Respondent replied that she had discussed those issues with the patient and was satisfied with his answers. Pharmacist DelBianco urged Respondent not to necessarily take the patient's word at face value, but to check with the other practitioners and pharmacies. Respondent became aggravated by Pharmacist DelBianco's questioning, and terminated the conversation.

56. Respondent did not check with other practitioners, despite being warned about the potential abuse and/or diversion of prescription medications by her patient, "H". Eighteen days later, on 5/18/93, Respondent wrote prescriptions for "H" for another 100 tablets of Tylox and 50 tablets of Valium.

57. A physician may only write a prescription in good faith and may not write any prescription outside the course of professional practice as set forth in 18 V.S.A. § 4214.

58. Based on the facts alleged in paragraphs 46 through 57, Respondent has prescribed drugs for other than legal or legitimate therapeutic purposes, which constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(6).

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59. By her actions as alleged in Paragraphs 46 through 57, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT VII (Patient "I")

60. In February of 1988, Respondent began treating three-year-old patient "I" (d/o/b 2/7/85), a child with an early history of abuse and neglect. Respondent diagnosed the child as suffering from a bipolar disorder and/or seasonal affect disorder. She treated the child with Tegretol, then Lithium and finally, by September of 1988, Respondent was prescribing Amitriptyline. During October of 1988, "I" was also prescribed Mellaril, an antipsychotic medication.

61. The use of any medication is necessarily predicated on a sound diagnosis derived by the application of established principles and protocols. The use of antipsychotic and antidepressant medication in young children may be undertaken only when a thorough evaluation and assessment of the patient, with careful regard given to differential diagnoses, leads the practitioner to a diagnosis which may justify their use. Then, treatment must proceed with extreme care, pursuant to a

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well-reasoned treatment plan which includes vigilant monitoring and follow-up. In difficult cases, such as the one presented by patient "I", consultations with experts are appropriate and expected as part of the treatment plan.

62. Respondent's management of "I's" case was deficient and substandard. Respondent failed to adequately evaluate patient "I" with the range of tools and protocols expected to be used prior to arriving at any diagnosis. Respondent failed to document her reasoning regarding "I's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent prescribed potent antipsychotic and antidepressant drugs based on an inconclusive foundation and then failed to provide adequate monitoring and follow-up. Respondent failed to obtain any consultations regarding the management of patient "I".

63. Respondent's management of "I's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

64. Alternatively, by repeatedly prescribing several potent anti-psychotic and antidepressant drugs to "I" under

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the conditions as described in Paragraphs 60, 61 and 62, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT VIII (Patient "J")

65. Patient "J" (d/o/b/ 8/20/89) was approximately 2 years, 9 months old when Sheila Conroy diagnosed and commenced treatment in May of 1992. Sheila Conroy, as stated in Paragraph 5 above, was not licensed as a health professional in the State of Vermont during the time period of these charges.

66. On June 12, 1992, Respondent wrote a prescription for Amitriptyline, 10 mg. for patient "J" at the request of Sheila Conroy. Respondent performed no physical or mental examination of "J" prior to providing this prescription for him, relying instead on the representations of Ms. Conroy and informal observations of the child during previous office visits of "J's" mother, "K", who was Respondent's patient. Based on this information, Respondent formed the belief that "J" was suffering from a major depression.

67. On June 19, 1992, "J" was seen by his family doctor, who had concerns that such a young child was being prescribed

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amitriptyline and that "J's" mother "cannot tell me the exact reason why". The doctor suggested to "J's" mother that she review "J's" medications with Respondent. The doctor also noted that he did not feel the child "has an active depression based on my interactions with him".

68. On or about June 30, 1992, Respondent increased the prescription to 25 mg. Amitriptyline for "J".

69. The use of any medication is necessarily predicated on a sound diagnosis derived by the application of established principles and protocols. The use of antipsychotic and antidepressant medication in young children may be undertaken only when a thorough evaluation and assessment of the patient, with careful regard given to differential diagnoses, leads the practitioner to a diagnosis which may justify their use. Then, treatment must proceed with extreme care, pursuant to a well-reasoned treatment plan which includes vigilant monitoring and follow-up.

70. It is mandatory that, prior to engaging in a treatment plan, the patient (or in the case of a minor child, his/her parent or guardian) is informed of the nature and character of the diagnosis, the range of potential treatments, the risks and benefits of potential treatments and the follow-up necessary to effectuate the treatment plan, and agrees to the treatment plan based on this information. This is characteristically called "informed consent".

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71. Respondent's management of "J's" case was deficient and substandard. Respondent failed to adequately evaluate patient "J" with the range of tools and protocols expected to be used prior to arriving at any diagnosis, relying instead on a few informal observations of "J" and the report of Sheila Conroy to base her diagnosis of a major depressive disorder. Respondent performed no direct physical exam of "J". Respondent failed to document her reasoning regarding "J's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent prescribed a potent antidepressant drug based on an inconclusive foundation and then failed to provide adequate monitoring and follow-up. Respondent failed to obtain informed consent from "J's" mother, "K".

72. Respondent's management of "J's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

73. Alternatively, by repeatedly prescribing a potent anti-psychotic and antidepressant drug to "J" under the conditions as described in Paragraphs 65 through 71, Respondent has engaged in unprofessional conduct under 26

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V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT IX (Patient "K")

74. Patient "K" (d/o/b/ 10/12/70) is the mother of patient "J" (see Count VIII above). According to Respondent, "K" first presented to, Sheila Conroy on May 11, 1992, "symptoms of depression, obsession, panic and paranoia". Sheila Conroy, as stated in Paragraph 5 above, is not licensed as a health professional in the State of Vermont.

75. Respondent maintained that patient "K" suffered from major depressive disorder, obsessive-compulsive disorder, and severe anxiety with panic, phobia, and "some psychotic features". Respondent characterized the patient's symptoms as "severe".

76. Despite the severe psychiatric problems presented by patient "K", Respondent allowed her to remain in the care of Sheila Conroy throughout the summer of 1992, seeing "K" only on two occasions, May 28, 1992 and June 26, 1992. Sheila Conroy saw patient "K" approximately 19 times through the end of July.

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77. From May 28, 1992 through July 29, 1992, patient "K" received 21 prescriptions for medications. These medications included Perphenazine, Imipramine, Xanax, Anafranil, Klonopin, and Benzotropine. Respondent maintains that all prescriptions from her office are authorized by her. However, the record does not support that Respondent was consulted by Sheila Conroy prior to the prescribing of medications, nor does the record support that Respondent personally performed any examinations or conducted any evaluations of patient "K", other than possibly on May 27 and June 26, prior to the authorization of prescription medications.

78. Respondent maintained that patient "K's" mental state was improving over the course of the summer, but that she continued to exhibit symptoms of anxiety and "lesser degrees of depression and paranoia". During a visit on July 22 with Sheila Conroy, "K" expressed feeling like she was going to "explode"; that her heart was racing; that she was having anxiety attacks all day; that she couldn't think straight and couldn't remember anything; that she had paranoid thoughts and "feelings of doom". At a visit on July 29 with Sheila Conroy, "K" stated that she was feeling very angry, irritable and that she "blacks out" when she gets angry.

79. On or about August 4, 1992, patient "K" was admitted to Rutland Regional Medical Center because of a suicide attempt. Respondent characterized "K's" actions as "more of a gesture than a serious suicide effort".

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80. It is mandatory that, prior to engaging in a treatment plan, the patient is informed of the nature and character of the diagnosis, the range of potential treatments, the risks and benefits of potential treatments and the follow-up necessary to effectuate the treatment plan, and then agrees to the treatment plan based on this information. This is characteristically called "informed consent".

81. Respondent's management of "K's" case was deficient and substandard. Respondent failed to adequately evaluate patient "K" with the range of tools and protocols expected to be used prior to arriving at any diagnosis. Respondent performed no direct physical exam of "K". Respondent failed to document her reasoning regarding "K's" diagnosis relative to the data gathered and other potential diagnoses. Respondent failed to articulate a cogent treatment plan. Respondent deferred management of "K's" case, characterized as "severe" by Respondent, to an unqualified caregiver, Sheila Conroy. Respondent allowed Sheila Conroy to adjust and prescribe potent psychotropic medications for "K" and/or Respondent prescribed such medications to "K" without personal examination or evaluation, based solely on the representations of Sheila Conroy. Respondent failed to provide adequate monitoring and follow-up. Respondent failed to obtain documented informed consent from "K".

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82. Respondent's management of "K's" case constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under same or similar conditions, whether or not actual injury to a patient has occurred.

83. Alternatively, by repeatedly prescribing a combination of several potent drugs to "K" under the conditions as described in Paragraphs 74 through 81, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT X (Patient "L")

84. Respondent commenced diagnosis and treatment of patient "L", a 37 year-old woman, around March of 1990.

85. Over an approximately two year period, Respondent prescribed a variety of controlled and non-controlled medications to patient "L", including Methocarbamol, Amitriptyline, Perphenazine, Bentropine, Klonopin, Roxilox,

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Lorazepam, Diazepam, Perphenazine, Prozac, Trazodone, Kemadrin, Diphenhydramine, Cyclobenzaprine, Feldene, Xanax, Tylox, Chlorpromazine, and Anafranil.

86. According to Respondent, Patient "L" was also in treatment, at various times, for the disease of alcoholism.

87. Respondent's use and management of pharmaceuticals, especially the use of the benzodiazepine class of drugs over a protracted length of time in a patient with alcohol problems, constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XI (Patient "L")

88. Patient "L" has a documented history of cardiac problems. During a Friday evening appointment at Respondent's office in September of 1991, patient "L" complained of a racing heartbeat and chest pain. Respondent listened to "L's" heartbeat and told her that it was running at 200 beats per minute. Respondent dispensed 11 tablets of medication to "L", to be taken immediately in one dose. Eight of the tablets are believed by "L" to have been 5 mg. Diazepam

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tablets, and three of the tablets, yellow in color, were unknown to "L".

89. After 15 to 20 minutes, "L's" chest pain worsened and the rapid heartbeat had not abated. Respondent did not refer "L" to a cardiologist or suggest to "L" that she go to the hospital Emergency Room. Instead, Respondent ordered "L" to completely undress, put on a nightgown, and lay down on a convertible bed located in Respondent's office. Patient "L" did as she was told, and fell asleep on the bed.

90. Patient "L" awakened late on that Friday night to find Respondent in the bed beside her, with her arm draped over "L's" shoulder. "L" fell back to sleep.

91. Respondent lodged patient "L" in her office suite on Stratton Road throughout that weekend. From time to time during that weekend, "L's". care was entrusted to Respondent's friend, a person untrained in any health care profession. Respondent ordered that person to administer prescription medication to patient "L" in an amount and type similar to that dispensed by Respondent. Patient "L" awakened late on Saturday night to find the person in the bed beside her. "L" fell back to sleep.

92. By this conduct, Respondent evidenced a disregard for the confidentiality of "L's" health status and a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

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93. In December of 1991, Respondent and Sheila Conroy, instructed patient "L" to lodge and care for "M", another of Respondent's patients. "M" stayed with "L" until spring, 1992.

94. By interposing patient "L" into the management of another patient's care, Respondent evidences complete disregard for the confidentiality, health, safety and welfare of both patient "L" and patient "M". Respondent exhibits an utter lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

95. By her actions as alleged in Paragraphs 88 through 94, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

96. Alternatively, by her actions as alleged in Paragraphs 88 through 94, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful

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and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XII (Patient "L")

97. "L" was scheduled to appear pro se in Rutland Family Court on May 18, 1992 regarding highly contested issues of child custody. Respondent assured "L" that she would accompany "L" to the court proceeding and assist her. "L" relied on Respondent's representations.

98. On the day of the Court hearing, "L" met Respondent's patient/employee "N" on the steps of the Courthouse. "N" informed "L" that Respondent would not be able to accompany "L" to the Court due to illness, but that Respondent had sent "N" in her place.

99. Respondent had instructed patient/employee "N" to administer prescription medication to patient "L" before the hearing. The medication dispensed by patient/employee "N" to patient "L" was three tablets of 5 mg. Valium, a regulated drug, which "L" was instructed to take all at once. The administration of these drugs severely impaired "L's" ability to interact effectively with the Court, thereby jeopardizing both her legal position and her mental state.

100. Patient/employee "N" is not licensed as a nurse, intern, medical assistant or resident by the State of Vermont,

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nor is "N" a member of "L's" family. "N" is not authorized by law to dispense medications on behalf of Respondent.

101. In her interaction with "N" at the Family Court, it became obvious to "L" that Respondent's patient/employee "N" was fully aware of minute details of confidences shared by "L" with the Respondent during the course of therapy and within the therapeutic environment, evidencing a breach of confidentiality by Respondent and/or Sheila Conroy.

102. After the Family Court Hearing, "L" learned that Respondent was actually in her office and was not ill. "L" went back to Respondent's office to confront Respondent regarding the breach of confidentiality with patient/employee "N", and the failure to Respondent to accompany her to the Court proceeding as she had promised.

103. Respondent told "L" that she had not gone to the Court proceeding with "L" because "you ["L"] are not going to make a damn fool out of me".

104. "L" told Respondent that any further breaches of confidentiality would result in a lawsuit. Respondent then physically assaulted patient "L", placing "L" in fear for her personal safety.

105. Respondent physically shook patient "L" on at least two other occasions, without provocation, in the course of treatment, Respondent would berate, scream at and belittle patient "L", using loud, heated and profane language, evidencing a loss of control.

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106. By her actions as alleged in Paragraphs 97 through 105, Respondent engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under similar conditions.

107. Alternatively, by her actions as alleged in Paragraphs 97 through 105, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XIII (Patient "O")

A.

108. In November of 1989, Respondent began prescribing methadone for patient "O", a 37 year-old male with severe drug dependency problems. Respondent prescribed methadone to "O" for the purpose of treating his opiate addiction, controlling the pain and gradually bringing the dose of methadone down to a therapeutic level.

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109. Respondent admits that said prescriptions were given for the purpose of replacing the opiates abused by "O" but also claims that the methadone was prescribed to control chronic back pain. However, the primary effect of the prescriptions was the treatment of a narcotic addiction.

110. "O", although suffering from some back pain, did not consult with Respondent for purposes of management of chronic back pain, but rather sought her services for treatment of his depression.

111. Respondent prescribed methadone as well as other potent narcotic analgesics for "O", with full knowledge and understanding that she was attempting to undertake an opiate maintenance program. Respondent continued to prescribe large amounts of methadone and other narcotic analgesics for opiate maintenance, fraudulently justifying them as treatment for "O's" chronic back pain.

112. Methadone is a Schedule II narcotic prescription drug with a high potential for abuse and addiction. Methadone is used, under strictly controlled conditions, in maintenance treatment and detoxification treatment for people addicted to illegal opiates.

113. Methadone, as a powerful narcotic analgesic, may be used for the relief of severe pain, it must be used with extreme caution due to its addictive potential. Respondent's use of it in "O's" case was inappropriate.

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114. The use of methadone or any narcotic drug for the purpose of maintenance treatment or detoxification treatment of drug addiction is strictly regulated by federal law, and may not be legally undertaken without the appropriate federal licenses and certifications.

115. In accordance with the standards set forth in 21 U.S.C. Sec.823(g), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose.

116. Respondent did not have the federally required registration to dispense narcotic drugs for maintenance or detoxification treatment during her treatment of "O", and, therefore, was in violation of federal law.

117. In addition, the Code of Federal Regulations sets forth the "appropriate methods of professional practice" concerning the use of narcotic drugs for maintenance treatment or detoxification treatment of narcotic addicts. 21 C.F.R. §§ 291.501 and 291.505.

118. In her methadone maintenance of "O", Respondent violated the requirements for methadone maintenance treatment of narcotic addicts established in 21 C.F.R. §§ 291.501 and 291.505 as detailed below.

119. Respondent did not obtain the approval of the necessary governmental authorities before prescribing,

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administering, or dispensing methadone for her treatment of "O" as required by 21 C.F.R. § 291.505(b)(2)(iv).

120. Before treating "O" with methadone, Respondent did not determine whether "O" met the minimum standards for treatment as required by 21 C.F.R. § 291.505(d)(1)(i)(A) and (B), and did not record in "O's" record the criteria used to determine "O's" physiologic dependence and history of addiction as required by § 291.505(d)(1)(i)(C).

121. Before treating "O" with methadone, Respondent did not obtain "informed consent" from "O"; she did not ensure that all relevant facts concerning the use of methadone were explained to "O" as required by 21 C.F.R. § 505(d)(1)(ii).

122. Respondent did not complete an initial drug-screening test or analysis for "O" and did not perform additional random tests or analyses during her treatment of "O" as required by 21 C.F.R. § 291.505(d)(2)(i).

123. Respondent did not perform the minimum medical evaluation of "O" as required by 21 C.F.R. § 291.505(d)(3)(i) and did not record the findings of such evaluation as required by § 291.505(d)(3)(ii).

124. Prior to treating "O" with methadone, Respondent did not have "O" interviewed by a well-trained drug treatment program counselor to determine the appropriate treatment plan for "O", as required by 21 C.F.R. § 291.505(d)(3)(iii).

125. Respondent did not establish a treatment plan as required by § 291.505(d)(3)(iv).

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126. Respondent did not complete a periodic treatment plan evaluation for "O" and did not ensure that such plan became a part of "O's" record as required by 21 C.F.R. § 291.505(d)(3)(v). Respondent started "O" on 60 milligrams of methadone a day on 11/7/89, thereby failing to ensure that the initial dose of methadone did not exceed 30 milligrams and that the total dose for the first day did not exceed 40 milligrams as required 21 C.F.R. § 291.505(d)(6)(i)(A).

127. Before giving "O" take-home methadone, Respondent did not determine whether "O" would be responsible in handling narcotic drugs according to the standards set forth in 21 C.F.R. § 291.505(d)(6)(iv)(B), and did not record any such determination in "O's" record, all of which is required by 21 C.F.R. § 291.505(d)(6)(iv)(A).

128. Respondent did not observe "O" on a daily basis or 6 days a week during the course of his methadone treatment, did not follow the criteria for reducing that frequency, and did not limit the take-home methadone to a 2-day supply as required by 21 C.F.R. § 291.505(d)(6)(v)(A)(1). Further, none of the exceptions from the take-home requirements listed in § 291.505 (d)(6)(vi) is applicable and, in any event, Respondent did not record a rationale for an exception in the patient's record as required by that subdivision.

129. Short term detoxification treatment is regulated by 21 C.F.R. § 291.505(d)(8) and is defined in the portion of (a)(1)(i) as follows:

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Short-term detoxification treatment is for a period not in excess of 30 days.

130. To the extent that Respondent considered her treatment of this patient to be short-term detoxification rather than drug maintenance, she violated several of the standards set forth in 21 C.F.R. § 291.505(d)(8).

131. Respondent did not administer methadone to "O" daily, under close observation, in reducing dosages over a period not to exceed 30 days as required by 21 C.F.R. § 291.505(d)(8)(i).

132. Respondent gave "O" take-home medication in violation of 21 C.F.R. § 291.505(d)(8)(i)(A).

133. Respondent did not perform an initial drug screening test as required by 21 C.F.R. § 291.505(d)(8)(i)(D).

134. Long-term detoxification treatment is regulated by 21 C.F.R. § 291.505(d)(9) and is defined in the portion of (a)(1)(ii) as: "Long-term detoxification treatment is for a period more than 30 days but not in excess of 180 days".

135. To the extent that Respondent considered her treatment of this patient to be long-term detoxification rather than short-term detoxification or drug maintenance, she violated several of the standards set forth in 21 C.F.R. § 291.505(d)(9).

136. Respondent did not observe "O" while he ingested methadone daily or at least 6 days a week for the duration of his long-term detoxification treatment as required by 21 C.F.R. § 291.505(d)(9)(A).

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137. Respondent did not document in "O's" record that short-term detoxification was not a sufficiently long enough treatment course before "O" began long-term detoxification as required by 21 C.F.R. § 291.505(d)(9)(C).

138. Respondent did not perform an initial drug screening test or analysis and did not perform at least one additional random test or analysis on "O" monthly during his long-term detoxification as required by 21 C.F.R. § 291.505(d)(9)(E).

139. Respondent did not prepare the required periodic treatment plan evaluation on "O" monthly as required by 21 C.F.R. § 291.505(d)(9)(F).

B.

140. During the summer of 1990, Respondent obtained controlled and non-controlled prescription drugs for dispensing and administering in her office by writing prescriptions for a patient, "O", who was then specifically instructed to fill the prescriptions and then return them to her. These medications were then re-dispensed to patients other than those for whom the original prescriptions were written.

141. This conduct contravenes 18 V.S.A. § 4214, which sets forth the professional use of regulated drugs; and 21 U.S.C. § 829, which sets forth prescriptions requirements. Such conduct also compromises the safety of drug products by contamination or adulteration, and jeopardizes patient care and protection.

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142. By these actions, Respondent has failed to comply with the record-keeping, inventory and reporting requirements set forth in 18 U.S.C. §§ 827 and 828, in 21 C.F.R. §§ 1304 and 1305, and in 18 V.S.A. § 4210.

143. Such conduct discourages the accurate accounting of drugs dispensed by Respondent and received by her patients, and results in lessened scrutiny of her use of pharmaceuticals.

144. By engaging patients in a scheme to procure prescription drugs for use in her office contrary to state and federal law, Respondent evidenced a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting and failed to recognize detrimental effects that a breach of those boundaries might have on the patient, thus seriously compromising patient care.

C.

145. 18 V.S.A. Sec. 4217 states as follows:

> It shall be the duty of every physician and every hospital to report to the board of health, promptly, all cases wherein a person has been or is being treated for the use of, or for problems arising from the use of, regulated drugs. Said reports shall include the type of problem being treated, the class of regulated drug which was used and such further information as is required by regulation of the board of health as promulgated under section 4202 of this title, except that the regulations shall not require the listing or other identification of the names of the persons being so treated.

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146. Respondent has failed to file any reports with the Vermont Department of Health regarding her detoxification and/or maintenance treatment of this patient.

D.

147. At Respondent's request, patient "O" sat in during initial sessions with at least one other set of patients, a couple who were attempting to undergo a opiate detoxification and maintenance program. During these sessions, at which both the other patients and Respondent were present, patient "O" was consulted by Respondent and patient "O" suggested various avenues, including specific drug regimens, which might be implemented for detoxification and maintenance treatment. During these sessions, patients disclosed confidential information regarding their lives and their addiction to both Respondent and patient "O".

148. By interposing patient "O" into the management of other patient's care, Respondent evidenced complete disregard for the confidentiality, health, safety and welfare of both patient "O" and the other patient(s). Respondent showed a lack of comprehension or disregard for the fundamental principles of doctor-patient boundaries as they must exist within the psychiatric therapeutic setting.

E.

149. Ostensibly to confront gender identity issues in patient "O's" life stemming from a physically and emotionally abusive childhood, Respondent instructed patient "O", on at

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least four separate occasions, to cross-dress and come to her office. These sessions took place late in the evening at Respondent's office on Stratton Road, after normal office hours.

150. During these sessions, Respondent would caress patient "O" on the face, neck, arms and thighs, and have him "pose" in various positions in an attempt to have him portray himself as a female. Respondent would encourage "O" to caress her arms. These sessions with Respondent were not an attempt at therapy but were sexually exploitative and demeaning.

151. In the course of treatment, Respondent would repeatedly engage in heated arguments with "O" over therapeutic issues. During these outbursts, Respondent would scream at patient "O", using loud, heated and profane language, evidencing a loss of control.

152. The conduct alleged in Paragraphs 108 through 141 Respondent has prescribed drugs for other than legal and legitimate therapeutic purposes. 26 V.S.A. § 1354(6).

153. The conduct alleged in Paragraph 145 and 146 constitutes unprofessional conduct as set forth in 26 V.S.A. § 1354(9), in that Respondent willfully omitted to file or record medical reports required by law.

154. By her actions as alleged in Paragraphs 108 through 151, Respondent has engaged in unprofessional conduct as set forth in 26 V.S.A. § 1354(22) in that in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency

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which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

155. Alternatively, by her actions as alleged in Paragraphs 108 through 151, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that in the course of practice, she failed to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

COUNT XIV

156. With reference to the above-alleged conduct, when considered in combination, Respondent has engaged in unprofessional conduct under 26 V.S.A. § 1354(22) in that she has failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred.

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WHEREFORE, Respondent should be reprimanded or her license made subject to conditions, limits, suspension, or revocation, as the Board deems appropriate under the circumstances.

DATED: July 6, 1994

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

by: Sally S. Hackett
Sally Hackett, Secretary

Date entered: July 7, 1994

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ENTRY ORDER

SUPREME COURT DOCKET NO. 1999-389

NOVEMBER TERM, 2000

Annette Lynch, MD	}	APPEALED FROM:
	}	
v.	}	Washington Superior Court
	}	
Office of Professional Regulation	}	
	}	DOCKET NO. 121-3-98Wncv
		Trial Judge: David A. Jenkins

In the above-entitled cause, the Clerk will enter:

Appellant Annette Lynch asks us to reverse a decision of the Board of Medical Practice revoking her license to practice medicine and establishing conditions for her reinstatement. On appeal she argues that she was improperly denied the opportunity to make an oral argument before the Board and that the Board's findings, specifically those regarding Lynch's violations of relevant standards of care, are not supported by the record. We affirm.

The following background findings by the Board are undisputed. Dr. Lynch received most of her professional training in Australia, where she specialized in gastroenterology. She did post-graduate work in England before teaching at a medical school in Philadelphia. Between 1980 and 1982, Lynch completed a two-year fellowship in child psychiatry at the Medical College of Pennsylvania. In 1986, after working at various mental health centers and hospitals, she began describing herself as a psychiatrist. In 1988, Lynch came to Vermont where she worked as a child psychiatrist at Rutland Mental Health Services for six months, after which she entered private practice. She is not eligible to be board certified in psychiatry. In Vermont, psychiatrists are not specifically licensed as psychiatrists; rather, practitioners are awarded a general license to practice medicine, allowing doctors to choose their own title or specialty.

The charges of unprofessional conduct before the Board of Medical Practice stem from Lynch's private practice. She was charged with thirteen counts of misconduct based on her care of a number of patients. After a sixteen-day hearing before a Board hearing committee, the committee submitted a final report to the Board. After modifying several findings in the report, the Board adopted it and issued a decision finding that Lynch had violated relevant standards of care with respect to ten patients. Lynch appealed the decision under 3 V.S.A. § 130a to an appellate officer, who affirmed the decision of the Board. Lynch then appealed to the superior court, which likewise affirmed the decision. She now appeals to this Court.

Lynch's first argument on appeal is that she was improperly denied oral argument, which resulted in prejudice, requiring reversal of the Board's decision. See 3 V.S.A. § 811 (requiring, under Administrative Procedure Act, an opportunity for oral argument before adoption of proposed adverse decision by an agency when a majority of members of decisional body have not heard the case or read the record). Lynch mistakenly submitted to the hearing panel her request for oral argument before the Board. The motion was included with other requests for relief. These other requests were properly directed to the hearing panel, but the panel also ruled on the motion for oral argument – denying it. Lynch did not, however, bring this error or her underlying request for oral argument to the attention of the Board. Arguably, because she did not bring the mistake to the attention of the Board, it should not be considered by this Court on appeal. See Brody v. Barasch, 155 Vt. 103, 108, 582 A.2d 132, 137 (1990) (plaintiff never raised issue of inadequacy of notice before the appeals officer and hence waived that issue); Hinckley v. Town of Jericho, 149 Vt. 345, 346, 543 A.2d 260, 261 (1988) (objections about notice of the hearing and procedures followed were not made before administrative body and were thus waived).

Nevertheless, even if the issue is properly before us, we cannot say that the mistaken denial of oral argument by the hearing committee in this case was an error of such magnitude as to require reversal. Reversal of a Board decision is warranted only if the claimed error, including statutory and procedural errors, prejudiced substantial rights of the individual charged with unprofessional conduct. See 3 V.S.A. § 130a (in appeals from decisions of boards of professional regulation, appellate officer may reverse decision if substantial rights of appellant are prejudiced by an error of the board). This standard is analogous to the one found in V.R.C.P. 61 (allowing reversal of trial court only when claimed error affects substantial rights; reversal appropriate where refusal to do so is at odds with substantial justice). Thus, the decision of the Board should not be reversed unless the claimed error substantively and prejudicially affected Lynch. Cf. Hinckley, 149 Vt. at 346, 543 A.2d at 261 (applying Rule 61 analysis to determine whether claimed errors rendered proceedings fundamentally unfair); Ordinetz v. Springfield Family Ctr., Inc., 142 Vt. 466, 470, 457 A.2d 282, 284 (1983) (noting that when undertaking Rule 61 analysis, test requires examination of how court's ruling affected the rights of the party substantively, not merely procedurally).

Lynch's claim of prejudice rests primarily on her argument she might have persuaded the Board to alter some of its findings. As noted by another court, "[a]rgument by counsel serves only to elucidate the legal principles and their application to the facts at hand; it cannot create the factual predicate." Spradlin v. Lear Siegler Mgmt. Servs. Co., 926 F.2d 865, 869 (9th Cir. 1991). When there is a well-developed record and there has been an opportunity to present written legal argument, courts have concluded that the denial of oral argument is harmless. See, e.g., Partridge v. Reich, 141 F.3d 920, 926 (9th Cir. 1998) (despite mandatory nature of requirement in jurisdiction that oral argument be afforded to party prior to adverse decision on summary judgment motion, if no prejudice results it will not be considered reversible error – court discerned no prejudice where party had ample opportunity to develop factual record at administrative level); Spradlin, 926 F.2d at 869 (finding no prejudice flowing from denial of oral argument where party "had every opportunity in the court below to offer specific factual allegations in support of his arguments"); Bratt v. IBM Corp., 785 F.2d 352, 363-64 (1st Cir. 1986) (party had ample opportunity to develop both factual

and legal arguments in the course of the proceedings, therefore no prejudice resulted from the denial of his request for oral argument). Here, the Board had all the evidence before it and had the benefit of a sixty-two-page brief from Lynch when making its final decision. Cf. Partridge, 141 F.3d at 926 (" 'When a party has [had] an adequate opportunity to provide the trial court with evidence and a memorandum of law, there is no prejudice [in a refusal to grant oral argument].' ") (quoting Lake at Las Vegas Investors Group, Inc. v. Pacific Malibu Dev. Corp., 933 F.2d 724, 729 (9th Cir. 1991)) (alterations in original). Thus, we likewise conclude that the lack of opportunity for oral argument is harmless.

Lynch also argues that the Board's findings are not supported by competent evidence in the record. We will not disturb findings of fact unless clearly erroneous, In re Smith, 169 Vt. 162, 174, 730 A.2d 605, 614 (1999), and will affirm the Board's conclusions as long as they are rationally derived from its findings and are based on a correct interpretation of the law. See Braun v. Bd. of Dental Exam'rs, 167 Vt. 110, 114, 702 A.2d 124, 127 (1997) ("we are concerned with the reasonableness of the Board's decision, not how we would have decided the case").

As part of her general argument regarding the Board's findings of misconduct, Lynch challenges the Board's use of treatises as evidence of the relevant standards of care. We note first that Lynch presented treatises to the Board without limitation on their use, and argued from them for this very purpose.[1] See State v. Longe, 170 Vt. 35, 39-40 n.*, 743 A.2d 569, 572 n.* (1999) (discussing invited error doctrine and noting "courts prevent a party from inducing an erroneous ruling and later seeking to profit from the legal consequences of having the ruling set aside") (internal quotation marks omitted); State v. Massey, 169 Vt. 180, 185, 730 A.2d 623, ___ (1999) (applying invited error doctrine and noting that a party must bear the responsibility for whatever prejudice flows from the admission of evidence it introduces). Additionally, given the more the liberal standards regarding the admission of evidence in administrative proceedings, 3 V.S.A. § 810(1); In re Quechee Lakes Corp., 154 Vt. 543, 552, 580 A.2d 957, 962 (1990), we cannot say that the use by the Board of treatises and articles – introduced by both parties without objection – in evaluating whether Lynch's conduct violated the standard of care was error. Cf. Orasan v. Agency for Health Care Admin., Bd. of Med., 668 So. 2d 1062, 1063 (Fla. Dist. Ct. App. 1996) (holding hearing officer committed reversible error by failing to admit excerpts of medical texts and treatises offered by doctor in proceeding before board of medicine, given the relaxed evidentiary standard regarding hearsay in administrative proceedings). Nor has Lynch pointed to any authority for the proposition that a board of professional regulation may not rely on texts or periodicals as evidence of a standard of care.

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[1] In her brief, Lynch indicates that some of the articles she introduced into evidence (she does not indicate which ones) "were expressly offered only to show the state of medical literature at the time in question concerning treatment of children for mania to show Dr. Lynch had a rational basis for what she did." (Emphasis added.) Lynch fails to explain how this is not evidence of whether Lynch was operating within accepted standards of care.

Lynch also challenges a significant number of the Board's findings on an individual basis. With the exception of one finding of fact regarding a patient for whom Lynch prescribed methadone,[2] Lynch does not challenge the Board's findings regarding her behavior that form the factual predicate of its decision. Rather, she challenges the Board's determinations that her conduct violated the standard of care. As we noted in Braun, such determinations require applying the facts to a standard of reasonableness and, thus, we defer to the factfinder's determination of whether behavior rises to the level of violating the standard of care and constitutes misconduct. Braun, 167 Vt. at 114, 702 A.2d at 126. Furthermore, this Court will give deference to the Board in determinations that are within its expertise. See Vt. State Colls. Faculty Fed'n v. Vt. State Colls., 151 Vt. 457, 460, 561 A.2d 417, 419-20 (1989) (noting that Court will normally defer to determinations made within expertise of administrative agency); see also Escobar v. Dep't of Prof'l Regulation, Bd. of Med., 560 So. 2d 1355, 1356 (Fla. Dist. Ct. App. 1990) (noting court is required to defer to medical board's expertise in the practice of medicine when reviewing its determination that doctor acted with recklessness); Hart v. Bd. of Healing Arts, 2 P.3d 797, 801 (Kan. Ct. App. 2000) (agreeing with lower court's statement that deference should be given to expertise of medical board on matters involving standards of care); Sugarman v. Bd. of Registration in Med., 662 N.E.2d 1020, 1026 (Mass. 1996) (deferring to medical board's expertise in determining proper sanctions for misconduct by physicians); In re Johnston, 663 P.2d 457, 466 (Wash. 1983) (noting court must defer to knowledge and expertise of medical board in its evaluation of the evidence). The standard of care governing a medical professional is just such a determination. See Braun, 167 Vt. at 115, 702 A.2d at 127 (noting Board of Dental Examiners, comprised primarily of dental professionals, may apply its own expertise in evaluating evidence regarding whether dentist violated standard of care); see also

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[2] Lynch argues that the Board's factual finding that her prescription of methadone to patient "O" was for his addiction problem and not for treatment of back pain is erroneous. Physicians are required to obtain a license to prescribe methadone for treatment of addiction, and the Board concluded that Lynch's failure to do so, and failure to comply with the requirements such as documentation and patient monitoring that accompany such a license, violated the standard of care. Both patient O and his wife specifically testified that they had contacted Lynch to help O deal with his opiate addiction, and that was what was discussed during O's initial visit, at which his wife was present. O also testified that Lynch never examined his back in that first visit, yet he left with a prescription for methadone. To the extent that Lynch argues that this testimony should be disregarded because of patient O's drug addiction, criminal history and his animosity towards Lynch, such matters bear on credibility, a determination we have stressed is the province of the factfinder. Cabot v. Cabot, 166 Vt. 485, 497, 697 A.2d 644, 652 (1997). Furthermore, this does not address the wife's testimony to the same effect, or testimony by a pharmacist that Lynch told him she had prescribed methadone for patient O to treat his addiction. Because the Board's determination regarding the purpose of the methadone prescription is supported by record evidence, we will not disturb it. Accordingly, Lynch's arguments regarding the prescription of methadone as a means to treat pain and the respective standard of care are not relevant and do not change the fact that the Board explicitly found that this was not the purpose of Lynch's prescription of methadone for patient O.

Rajan v. State Med. Bd., 692 N.E.2d 238, 245 (Ohio Ct. App. 1997) (noting majority of medical board members possess specialized knowledge needed to determine the standard of care and whether physician's conduct falls below that standard).

With regard to Lynch's specific arguments concerning patients "I," "J," "K" and "L," Lynch essentially argues that the Board merely disagreed with her diagnoses and ensuing treatment, which she contends is an insufficient ground on which to base a finding that she violated the standard of care. To the contrary, the basis of the Board's finding of misconduct was not a finding that Lynch made incorrect diagnoses. Rather, it found that Lynch did not undertake sufficient investigation and examination before both diagnosing unusual and serious mental illnesses in these patients, and prescribing powerful medications to treat them. Additionally, the Board found that Lynch failed to adequately monitor the patients' response to their treatment regimes for adverse consequences or document her revolving course of prescriptions. In other words, the Board found that Lynch's methods leading to the diagnoses and her follow-up on these diagnoses, not the diagnoses themselves, fell below the standard of care.

There was ample evidence in the record to support these determinations. For instance, one expert definitively testified that with regard to patient I, Lynch's methodology used to arrive at the child's diagnosis, including her failure to obtain a consultation with another doctor, grossly deviated from the standard of care. And with regard to patient J, even Lynch's own expert testified that Lynch's documentation fell below the standard of care, and that the limited information found there did not form an adequate basis for a diagnosis.

Lynch also contends that the Board's findings that her care of patients "A," "B" and "D" fell below an acceptable standard are not supported by sufficient evidence, in part because the Board failed to take into account the patients' socio-economic status. The Board was not bound to accept Lynch's arguments that differing standards of care apply regarding patients of lower economic status. There was repeated expert testimony that a reasonable and prudent physician, when confronted with the circumstances of each of these patients, would not have engaged in conduct such as that engaged in by Lynch, including entering into employer-employee relationships, sharing other patients' information with them, engaging in heated arguments with the patients stemming from their nonpatient relationships and opening a trustee checking account for one patient with herself as trustee. Furthermore, the Board found that even evaluating Lynch's conduct using the comprehensive psychiatric rehabilitation model, which she argued is the model she used to treat such economically disadvantaged patients,[3] Lynch failed to adhere to the standard of care.

In sum, our review of the record, taking into consideration the Board's specialized expertise, reveals that the Board's findings are supported by the evidence and that its conclusions regarding

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[3] The Board also found that Lynch failed to meet the standard of care governing the community psychiatry model, after which it determined Lynch attempted to pattern her practice.

Lynch's conduct are reasonable. Furthermore, the failure of the Board to rule on Lynch's motion for oral argument in this case did not result in prejudice that would require reversal. Accordingly, we discern no basis for disturbing the Board's disposition of this matter.

Affirmed.

BY THE COURT:

John A. Dooley, Associate Justice

☐ Publish

James L. Morse, Associate Justice

☐ Do Not Publish

Denise R. Johnson, Associate Justice

Brian L. Burgess, District Judge
Specially Assigned

Ernest W. Gibson III, Associate Justice (Ret.)
Specially Assigned

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

Docket Nos. MPN10-0790
MPN71-0690
MPN37-0593
MPN68-0892
MPN69-0892
MPN55-0490
MPN67-0892
MPN15-1089

In re Annette M. Lynch, M.D.	}	Hearings held at
	}	Montpelier, Vermont
	}	June 19, 1995
	}	June 20, 1995
	}	June 21, 1995
	}	June 22, 1995
	}	June 23, 1995
	}	June 26, 1995
	}	June 27, 1995
	}	June 28, 1995
	}	June 29, 1995
	}	August 7, 1995
	}	August 8, 1995
	}	August 11, 1995
	}	August 14, 1995
	}	August 15, 1995
	}	August 17, 1995
	}	August 18, 1995

PRESENT: Charles C. Cunningham, M.D., Hearing Committee Co-Chair
Priscilla B. Fox, J.D., Hearing Committee Co-Chair

APPEARANCES: Linda A. Purdy, Assistant Attorney General
for petitioner

Geoffrey A. Yudien, Assistant Attorney General
for petitioner

Kimberly B. Cheney, Esq.
for respondent

Ritchie E. Berger, Esq.
for respondent

Nanci A. Smith, Esq.
for respondent

Annette M. Lynch, M.D., respondent

HEARING COMMITTEE REPORT

This cause came before a hearing committee (committee) of the Board of Medical Practice (Board) on a specification of charges against Annette M. Lynch, M.D. (respondent). Having heard the evidence on the charges, the hearing committee has determined that the following findings of fact and conclusions of law are supported by the evidence.

Findings of Fact

The hearing committee carefully reviewed the proposed findings filed by both parties. As is evident in this report, the committee did not adopt the proposed findings filed by respondent. The committee did not adopt all of the proposed findings filed by petitioner, because some of those proposed findings were irrelevant, somewhat inaccurate, or unnecessary for the committee's decision.

However, for those proposed findings or portions of petitioner's proposed findings which it did adopt, the committee did an extensive amount of editing, re-writing, and fact-checking. In addition, this report contains a significant amount of independent work by the committee that is not based on proposed findings but rather is directly based on credible, relevant evidence offered by the parties and admitted at hearing.

Certain of the committee's findings containing quotes from journal articles appear in more than one count. The committee believes it is less confusing and more convenient for the reader simply to repeat these findings in each count to which they pertain rather than to attempt to cross-reference findings in different parts of the report.

General Findings I

1. Respondent Annette M. Lynch, M.D., is a physician licensed by the Board. She holds license number 42-0007669.

2. Under the Medical Practice Act, the Board does not license physicians by practice specialty. Instead, physicians licensed by the Board may designate their medical specialties themselves.

3. Respondent holds herself out as a psychiatrist and maintains a practice in psychiatry at her office in Rutland, Vermont. She is not board certified, nor is she board eligible, in psychiatry.

4. Respondent is the only physician in her office. Since 1990, she has worked in close clinical collaboration with Sheila Conroy. Ms. Conroy was not licensed in any regulated mental

health profession during the period of time covered by the charges. Ms. Conroy subsequently became licensed in Vermont as a clinical mental health counselor in 1994.

5. Respondent is Ms. Conroy's supervising physician. As such, she prescribes medications for Ms. Conroy's patients and bills insurance companies, Medicare, and Medicaid for Ms. Conroy's services.

6. Respondent operates a solo medical practice with an annual gross of approximately $180,000. She spends 50 to 60 hours per week in face-to-face visits with patients. She sometimes sees over 20 patients a day and, in addition, does a fair amount of crisis work. This reveals that the hours she spends per week with patients cannot leave much time for attention to medical recordkeeping and other essential administrative aspects of a solo practice.

7. The caseload of her practice, which she and Ms. Conroy handle mainly by themselves, is currently approximately 350 patients, many of them Medicare and Medicaid recipients. An agency-based practice group such as Associates in Child and Family Service at Rutland Mental Health Services, Inc., would employ approximately 12 full-time equivalent staff to deal with a similarly-sized caseload. Respondent's staffing is inadequate for her caseload under her "comprehensive rehabilitation" psychiatric practice model.

8. Respondent performs tasks in her private practice that would and should be handled by others at a community mental health center (e.g., trying to think of routine jobs for patients to perform and managing patient finances).

9. Respondent refers to her practice model as "comprehensive psychiatry," "psychiatric rehabilitation," or "comprehensive psychiatric rehabilitation." She contends that her model shows how a private practitioner can provide a full range of psychiatric rehabilitation services for patients.

Respondent's Credentials

10. Respondent received her professional training at the University of Sydney in Australia. The combination of her college and medical school training lasted six years, as is customary in Australia. During medical school, she trained in gastroenterology and did not focus on psychiatry as a chosen specialty. She was first licensed in Australia as a physician in 1961.

11. The early part of respondent's career consisted of research fellowships in gastroenterology in Australia and at the University of Pennsylvania. There were no formal mental health

components to those experiences, although respondent did become involved in the psychological aspects of her patients' care as part of the new "comprehensive care" method of practicing medicine then emerging.

12. Respondent studied for one year at the University of Bristol in England and received a degree from that institution in the field of public health. After that, she served as a county health officer in Essex County, England. She then returned to the University of Pennsylvania, where she worked as an assistant professor of epidemiology.

13. In 1969, Respondent became an associate professor at Hahnemann University in Philadelphia. At that institution, she worked for a year as medical director of the school's community clinic and neighborhood health center. Next, respondent worked for three years as the associate director of school health for the school district of Philadelphia. Then, respondent worked as the school health program coordinator for the State of Pennsylvania. During this time, she became board certified in preventive medicine and wrote a book entitled, Redesigning School Health Services.

14. Respondent completed a two-year fellowship in child psychiatry at the Medical College of Pennsylvania between 1980 and 1982, after leaving her job in the school system.

15. Typically, a child psychiatrist receives at least two years of training in adult psychiatry and two years of training in child psychiatry. Respondent never received formal training in adult psychiatry and, in that respect, her education was not as extensive as that of most physicians who hold themselves out as being psychiatrists, including Drs. Rabinovich, Dennett, and Coyne, who testified in these proceedings.

16. Following completion of her fellowship, she spent aproximately a year and a half working at various community mental health centers in Philadelphia. After that, she worked for the Department of Welfare and with the Philadelphia State Hospital. Around 1986, while still in Pennsylvania, she began to describe herself as a psychiatrist.

17. Respondent came to Vermont in 1988. She obtained a job as a child psychiatrist at Rutland Mental Health Services, Inc. She held that job for six months, until August 1988. She then entered into private practice in Rutland, Vermont.

18. Soon after she left Rutland Mental Health Services, that organization filed a complaint about her with the Board for her failure to complete medical records on patients she had seen before she left the employment of Rutland Mental Health Services. Within a year of her entry into private practice, Rutland Mental

Health stopped referring patients to her.

19. In 1990, the Rutland Regional Medical Center (RRMC) temporarily suspended her hospital privileges because of the unacceptable quality of care she rendered to patients. Eventually, after a case review by at least two psychiatrists, she resigned her privileges there. Respondent does not hold hospital privileges in Vermont, New York, or New Hampshire.

20. The Vermont Department of Social and Rehabilitation Services (SRS) no longer refers clients to respondent. SRS filed complaints with the Board regarding twelve different patients respondent had treated.

21. During the spring of 1995, respondent's federal Drug Enforcement Administration (DEA) license renewal form was mislaid in her office. As a result, her DEA license expired, and she prescribed controlled drugs for awhile without it.

22. Since 1989, respondent has had no arrangements for backup assistance by another physician in the event of an emergency or if she is away on vacation. She does not have another psychiatrist-colleague with whom she can discuss cases. The only professional association to which she currently belongs is the American Women's Psychiatric Association. She has had problems getting her patients admitted to hospitals in Rutland, Burlington, and Hanover, New Hampshire. She obtains most of her patients by word-of-mouth referrals and only a small number from other professionals. These are all indications of her isolation as a practitioner.

Witness Credibility

Respondent

23. The hearing committee listened carefully to respondent during four days of hearings and observed her closely during 16 days of hearings. Respondent was not a credible witness.

24. Respondent would have the hearing committee believe that she is at all times a sober, restrained professional incapable of slapping patients or of yelling or swearing at them.

25. The testimony of numerous credible witnesses directly contradicted the impression of sober restraint that respondent sought to create at the hearings.

26. Respondent denied ever slapping, screaming, yelling, or swearing at patients. Yet numerous patients (e.g., Patients C, O, and [redacted] (Patient L)) and others (e.g., [redacted] Witness G, and Patient D's sister-in-law) described such actions. One witness, [redacted]

vividly demonstrated on counsel for respondent a severe, strong shaking of [redacted] by respondent.

27. Some of [redacted] interaction with Patient N before [redacted] court hearing was driven by both patients' knowledge of respondent's terrible temper.

28. Patients C, E, and O recounted episodes where respondent swore at them or at others. Witness P (Patient O's estranged wife) overheard respondent use loud, vulgar language with someone.

29. Patient C, [redacted] and [redacted] recounted episodes where respondent forcefully shook Patient C, [redacted] or other patients.

30. Patient C and [redacted] recounted episodes where respondent hit them.

31. Patients E, C, O, and [redacted] recounted how respondent called them names and verbally humiliated them in other ways.

32. Patients C, E, O, [redacted] Witness G, and [redacted] recounted episodes where respondent screamed or yelled at them or at other patients.

33. In Patient C's case, respondent admitted that she raised her voice with Patient C but attempted to explain it away by saying that sometimes psychiatrists must raise their voices when dealing with distraught patients.

34. Respondent's explanation is rejected. Raising her voice as she did in the circumstances involving Patient C and other patients and witnesses is not acceptable conduct for a psychiatrist or any other physician.

35. Respondent's attempt to portray herself as being at all times a sober, restrained professional incapable of slapping patients or of yelling or swearing at them is rejected.

36. Respondent has a fierce temper and used it to manipulate her patients and others. She swore at patients and others, called them names, and humiliated them. She shook and hit patients. She screamed and yelled at patients and others.

37. [DELETED]

38. [DELETED]

39. Respondent would have the hearing committee believe that with her minimal training and experience in psychiatry and without the collaboration or cooperation of any significant

community support systems, she can effectively diagnose, treat, and appropriately medicate the most difficult types of psychiatric patients in her small, private, solo medical practice,--patients who have not been treated successfully by others or patients with multiple psychiatric conditions, or both. The evidence presented in these proceedings conclusively refutes respondent's contention.

40. Respondent recently founded a private, non-profit organization, the Vermont Center for Psychiatric Rehabilitation and Community Support. This organization is still in the formative stages, but its goal is to create rehabilitation communities of care and support for people with psychiatric disabilities.

41. In its brochure, the Center claims that it will demonstrate how small psychiatric and mental health practices can provide psychiatric rehabilitation and community support services to their clients by creating a community network of care and services, educating professionals, providing consultation to other practices, disseminating information about psychiatric rehabilitation and community support services, and conducting research on the value, effectiveness, and outcome of psychiatric rehabilitation and community support services.

42. Respondent should have had such a framework in place when she started her private psychiatric practice in 1988. Instead, she plunged ahead without any supporting framework and without adequate training, assuming that she could handle difficult, severely mentally ill patients by herself. Only recently, after serious complaints about her practice had been filed with the Board, did she set about establishing a framework through the proposed Center. Her timing casts doubt upon her motives and underscores the inadequacy of her previous treatment of the complaining patients.

Patients and Their Relatives

43. By contrast, the patients who testified at the hearings were credible witnesses on most points. They and some of their relatives testified about the patients' mental and physical states while under respondent's treatment. Despite laboring under serious disabilities, many of these patient-witnesses displayed considerable courage by coming before the hearing committee, in the intimidating environment of a formal hearing, to present their evidence.

44. Many of the patient-witnesses did not know each other. Furthermore, they were sequestered before testifying and so did not listen to, and were not influenced by, the testimony of the patient-witnesses who preceded them.

45. The fact that some of these patient-witnesses have filed civil lawsuits against respondent does not detract from their credibility. These patients had much to lose by testifying in these proceedings. They had to testify about embarrassing and humiliating personal medical matters in open hearings attended by the press and public. They had no foreknowledge of the outcome of the hearings. If the evidence presented had exonerated respondent, their chances of recovery in any civil lawsuits they had filed would have been greatly decreased.

46. The testimony of many of the patient-witnesses was similar in certain respects. For example, several different patient-witnesses recounted how respondent yelled and swore at them. Two patients, C and O, recounted how respondent had them write or re-write documents to cast respondent's conduct in a better light. The similarities in the testimony of these patient-witnesses adds to their credibility and detracts from respondent's credibility.

47. Besides relating the facts surrounding their medical treatment by respondent, some of the patient witnesses provided their opinions and inferences about that medical treatment. Their opinions and inferences were based on their own perceptions and were crucial in helping the hearing committee to gain a clear understanding of their testimony and to determine the facts at issue in this case.

48. [DELETED]

49. [DELETED]

50. Patient B was a credible witness. Although she has suffered from serious mental illness, she testified in a straightforward and coherent fashion at the hearings. She did not hesitate or equivocate in her testimony.

51. Patient C was a credible witness. Her testimony was very articulate, and she chose her words carefully. Her description of her admiration of respondent, which later changed to fear and feelings of deep humiliation, was thoroughly convincing.

52. Patient D is deceased and therefore could not testify in these proceedings. Patient D's sister-in-law testified, however. Her testimony about respondent's treatment of Patient D was credible, and her testimony was not shaken by cross-examination.

53. Patient E, a young woman, suffers from serious mental disabilities. Her testimony was less articulate and coherent than that of some of the other patients who testified. At times she showed poor understanding of the questions asked of her at

the hearings. Her memory of some events was also somewhat shaky. However, she spoke convincingly of how bad she felt after certain episodes involving respondent, such as the misunderstanding about getting paid for mowing respondent's lawn.

54. Witness G (Patient E's mother), while not as well-spoken or well-educated as some of the other patients and witnesses, was nevertheless a credible witness. She observed her daughter under respondent's care and related her observations to the hearing committee in a simple, no-nonsense manner.

55. Patient I is a young juvenile and so did not testify in these proceedings. Her foster mother during the time period covered by the charges did testify, however. The foster mother's testimony was not credible on such points as respondent's communications with patients' families and Social and Rehabilitation Services (SRS).

56. The foster mother's testimony was at odds with testimony of Patient I's social worker, Erica (Lee) Tamblini, on the issue of respondent's communications in the case of Patient I. The foster mother's testimony was also at odds with the testimony of numerous other witnesses on the issue of respondent's communication practices in general.

57. Although the foster mother stated that she felt no hostility toward SRS, her credibility was undermined by the fact that soon after Patient I was removed from the foster mother's home, SRS discovered that one of the foster mother's sons had been sexually molesting Patient I while she was in the foster mother's home. Her credibility was also undermined by the fact that respondent has treated and still treats her and her family. The foster mother therefore had sufficient motivation to testify in contradiction to the SRS social worker's testimony.

58. Patient J is a young juvenile and so did not testify in these proceedings.

59. Patient K is Patient J's mother. She testified credibly about how she felt under respondent's treatment and how her son behaved under respondent's treatment. Her credibility was not undermined by the fact that she returned to respondent for treatment after her suicide attempt. She was addicted to Xanax and was a Medicaid recipient. She had to go to respondent for treatment, because she could not find another provider, and respondent was willing to prescribe Xanax for her.

60. [redacted] (Patient L) was a credible witness on most points. She has suffered from various disabilities and illnesses, including Munchausen Syndrome (factitious illnesses), for many years. However, her determination, despite her disabilities, to tell the committee what happened to her under

respondent's treatment, was impressive.

61. Two salient points on which [redacted] testimony was not credible were (a) the alleged physical contact between her and respondent and (b) the alleged physical contact between her and Witness S during her weekend stay at respondent's office. Her testimony on these points was not credible, because she had been medicated by respondent at the time and was too heavily sedated for her impressions about respondent or Witness S touching her or being in bed with her to be accurate.

62. Patient M was generally a credible witness, especially on the point of Sheila Conroy's role in arranging for Patient M to move in with [redacted] Patient M's testimony was also consistent with [redacted] testimony regarding episodes of [redacted] drinking with Patient M's boyfriend.

63. Patient O was an intelligent, articulate, and credible witness. He was straightforward in acknowledging his drug addiction and past lying and manipulative behavior. He did not attempt to evade answering questions at the hearings. His testimony withstood vigorous, aggressive cross-examination. The evidence presented demonstrated that he had a complex emotional relationship with respondent. His testimony at the hearings was consistent with this evidence.

64. Furthermore, Patient O's testimony about his addiction treatment and cross-dressing was corroborated by his estranged wife, Witness P. His testimony about respondent's treating him for addiction rather than pain is corroborated by Witness P and by the medical records. Patient O's testimony about respondent's screaming at him, pressuring him, and threatening him was corroborated by the testimony of other witnesses about similar actions taken by respondent against them.

65. Witness P, Patient O's estranged wife, was a credible witness. She presented her testimony in a firm, straightforward manner. The fact that she had previously been convicted of embezzling money from her employer did not destroy her credibility, because she admitted this incident in her past candidly and straightforwardly.

66. [redacted] was a credible witness. She was 17 at the time of the hearings, yet she testified with the composure of a mature adult. As a witness, she was sequestered from her mother and other witnesses before testifying, yet her testimony was consistent with her mother's. At the request of respondent's own counsel, she convincingly demonstrated the forceful manner in which respondent shook [redacted]

Physician Witnesses Other Than Respondent

67. The testimony of Douglas E. [illegible]nnett, M.D., was very credible. Contrary to respondent's assertions, he had no nefarious hidden agenda in testifying before the hearing committee. His purpose in testifying, as he indicated, was simply to provide an opportunity for the hearing committee and the parties to question him about standard-of-care issues raised in the charges. Any alleged inconsistencies in his testimony elicited during cross-examination were carefully and satisfactorily explained and corrected on re-direct examination. His testimony was direct and forthright and was not discredited by cross-examination.

68. The testimony of Mark R. Hoffman, M.D., family physician of Patients J and K, was also very credible. His testimony impressed the hearing committee as being honest, direct, and to the point. His picking up on the issue of Patient K's inability to explain why her son was being prescribed certain medications by respondent demonstrated his perceptiveness and concern about these particular patients.

69. The testimony of Seddon R. Savage, M.D., on the issues of why respondent prescribed methadone for Patient O and whether Patient O was a narcotics addict when respondent prescribed methadone for him, was not particularly helpul. She avoided questions and obfuscated the answers that she did provide. She demonstrated that she knows a great deal about the history of how the law has dealt with treatment of narcotics addiction, an interesting topic but one not central to these proceedings. The hearing committee has the impression that she testified in this case to advance her own agenda of persuading boards of medical practice to view methadone prescribing with leniency, so that physicians will not be dissuaded from under-prescribing for legitimate pain.

70. Nancy Coyne, M.D., testified on respondent's behalf but prepared for the hearings by reviewing summaries provided by respondent rather than actual patient records.

71. Before the hearings, she had not had contact with respondent for 25 years. This greatly diminished her credibility on how respondent acts now. She admitted that she had a fairly intimate, professionally close relationship with respondent in 1970, when respondent was her teacher and mentor during medical school. Her testimony appeared to the hearing committee to be influenced by her memories of respondent as her mentor and her desire to help her former teacher.

72. Her testimony was also weakened by her desire to advance her own agenda of pointing out the breakdown of the community mental health system. As she sees it, society sets up structures to help severely mentally ill people with their real needs, but the structures are often inaccessible to the people

who need them most, because helping such people requires a hands-on approach. Another part of her agenda in testifying was that she does not want to see medicine become a business where a great deal of money is poured into Medicaid and hospital emergency rooms but no provisions are made for vocational rehabilitation or dignified approaches to patients' life problems.

73. The testimony of Harris Rabinovich, M.D., was not as credible as Dr. Dennett's testimony. His testimony on respondent's behalf was undermined by his admission that his own career has been "on the edge" of accepted psychiatric practice. Also, while asserting on direct examination that respondent's medical records appeared to be adequate, he admitted on cross-examination that they were deficient and incomplete for Patients I and J.

74. His testimony was also undermined by his avowed personal agenda in testifying in these proceedings. He seeks to preserve the right of psychiatrists to treat very young children with powerful psychotropic medications.

Other Witnesses

75. Witness S's testimony was credible. She testified in a straightforward manner and did not attempt to evade questions. She impressed the hearing commmittee as being a forthright, no-nonsense person.

76. Pharmacist John Dorvee's testimony was credible. He had no ax to grind or hidden agenda to forward by testifying at the hearings. He presented his facts cogently and behaved with the utmost professionalism at the hearings.

77. The testimony of Erica (Lee) Tamblini, Patient I's social worker, was credible. Evidence in her own notes and in Patient I's medical records corroborates the difficulty she and others had in contacting respondent and the concerns they had for the medications respondent was prescribing for Patient I.

78. Music therapist Kelley Lyon-Haden's testimony was credible. Respondent attempted to show that she was disgruntled because of a pay dispute. Respondent's attempt did not discredit Ms. Lyon-Haden's testimony, however, because Ms. Lyon-Hayden appeared to the hearing committee to be honest and forthright. Evidence that both Patricia Kimball, an art therapist who worked for respondent, and Patient B also had difficulties getting paid by respondent supports the credibility of Ms. Lyon-Hayden with respect to her own pay dispute. Ms. Lyon-Hayden testified in a direct, forthright manner.

79. The testimony of respondent's associate, Sheila Conroy, was not credible. While testifying during the hearings, she

often looked to respondent for affirmation or confirmation of her testimony. She gave the hearing committee the impression that she is dominated by respondent's stronger personality and that, consequently, she testified in a manner calculated to please respondent.

Burden of Proof

80. The burden of proof in an administrative proceeding such as this is a preponderance of the evidence.

81. Even if the burden of proof were clear and convincing evidence, the facts of this case overwhelmingly support the determination that respondent's conduct was unprofessional, as set forth in this report.

Use of Expert Evidence

82. The hearing committee was comprised of a physician member of the Board and a public member (who is also an attorney with over ten years of work experience in health regulation). The hearing panel which will review the hearing committee's report includes additional physicians and an additional public member.

83. The hearing committee used its medical experience in reviewing and evaluating the evidence in this case. The hearing committee does not require expert testimony to reach decisions involving every aspect of the medical practice issues raised in this case. The same holds true when the hearing panel reviews the hearing committee's report.

84. Even if the hearing committee had possessed no medical experience with which to review and evaluate the evidence, the hearing committee's findings would not have changed, because Dr. Dennett's expert medical testimony was credible and was supported by other credible witnesses and exhibits offered by both parties and admitted by the hearing committee.

Journal Articles

85. Both parties submitted journal articles from the medical literature for review by the hearing committee. A careful reading of the journal articles revealed that they do not support respondent's position. When coupled with Dr. Dennett's testimony, they contain a wealth of information highly damaging to respondent's position. While the committee did not rely on the journal articles over and above the testimony of live witnesses and other exhibits, the articles did help significantly to illuminate some issues for the committee.

86. The journal articles on community psychiatry described

treatment provided in or by social service agencies and not treatment in a private practice setting such as respondent's. This significant difference in the literature undermined respondent's position.

87. The programs described in the literature frequently contained a component providing for evaluation of the programs themselves. Respondent's practice model lacked such a component.

88. The programs described in the literature typically have and require a great deal of contact with non-psychiatric community resources such as housing and welfare agencies. By contrast, respondent practices in isolation. Although she produced a list of social services in Rutland, she did not indicate much, if any, interaction with those services for the benefit of her patients. When SRS stopped referring patients to her, she lost one of her few remaining links to social service resources in the community.

89. Support services in programs described in the literature are typically provided by non-psychiatrists such as case managers and social workers. A psychiatrist can be a case manager, but a case manager does not provide therapeutic services: "A case manager does not provide therapeutic services but rather establishes a supportive and trusting relationship with the client for the purpose of assisting him or her with the complexities of living in the community." Resp. exh. A185. (Breakey, Networks of Services for the Seriously Mentally Ill in the Community, in Psychiatry Takes to the Streets 31 (N. Cohen, ed. 1990)).

90. "Six basic functions for case managers can be defined: (1) assessment of the service needs of the client, (2) development of a services plan, (3) connecting of clients to services, (4) monitoring of service provision, (5) maximizing of compliance, and (6) advocacy." Resp. exh. A185. (Breakey, Networks of Services for the Seriously Mentally Ill in the Community, in Psychiatry Takes to the Streets 31 (N. Cohen, ed. 1990)).

91. In her practice model, respondent attempted to provide both therapeutic and case manager services, with poor results.

92. The programs described in the literature provide staff training, formally monitor their clients' service plans and modify them to fit clients' needs, and do not use individual psychiatrists as Supplemental Security income (SSI) payees. Respondent did not incorporate these program attributes into her practice model.

93. In fact, the elements of a sound community psychiatry practice are conspicuous by their absence from respondent's

practice. This absence is not excused by respondent's claim that she does not practice community psychiatry but rather comprehensive psychiatric rehabilitation. She based her model on many aspects of community psychiatry.

94. Respondent failed to articulate a cogent plan for her practice or for patients individually, failed to provide staff training, failed to put an evaluation system in place, failed to attend any conferences or professional meetings about these topics during the time period at issue in this case, and failed to network effectively in the community. Her practice was characterized by organizational failure at every level, from sloppy recordkeeping and failure to return phone calls to lack of consistency with individual patients. She manipulated medication dosages with dizzying frequency and without any underlying documented rationale.

95. Furthermore, the community psychiatric models described in the literature relied upon by respondent were established with specific objectives, protocols, and, in some cases, research controls. Respondent's practice lacked these attributes.

96. For example, respondent frequently cited the "Madison Model" of community psychiatric care in Madison, Wisconsin, as an early prototype with elements she wished to incorporate into her own practice. Yet one of the journal articles about the Madison Model that she submitted described the problems encountered in adapting the model to other settings. The article pointed out that the problems in adapting the model are greater in other settings where few of the model's underpinnings are in place and where there is no history of support for local integration of psychiatric and social services. Based upon the testimony presented at the hearings, such would seem to be the situation in Rutland, where respondent practices. Resp. exh. A121 at 632. (Thompson, Griffith & Leaf, A Historical Review of the Madison Model of Community Care, 41 Hospital and Community Psychiatry 625, 632 (1990)).

97. The author of the only article submitted by respondent that was favorable to the practice of a psychiatrist taking patients home claimed to have obtained good therapeutic results, but none of the patients taken home by the author was totally indigent or even near indigent. Most of the patients were in college or had careers or marriages. The author of the article, Joseph S. Jacob, M.D., was careful to note that he did not urge on any therapist the alterations of therapeutic parameters caused by taking patients home. Resp. exh. A138 at 1, 4. (Jacob, Therapeutic Implications of Taking Patients Home Reviewed, The Psychiatric Times - Medicine & Behavior (Mar. 1992)).

98. By contrast, many of respondent's patients were single people without the support system of careers or marriages and

were in severe financial straits when she treated them. This difference means that the Jacob article lends little support to respondent's case.

99. On the subject of comprehensive psychiatric rehabilitation, which respondent claims to practice, the literature she submitted does not support her case. Among other things, comprehensive psychiatric rehabilitation encompasses self-care, family relations, peer and friendship relations, avocational and employment pursuits, money management and consumerism, residential living, recreational activities, transportation, food preparation, and choice and use of public agencies. As the literature submitted by respondent points out, because comprehensive rehabilitation involves so many areas of the patient's life, the responsible psychiatrist must galvanize the active involvement of the patient and the patient's family, as well as the full spectrum of community support services. Working as a solo private practitioner, respondent was never able to galvanize anywhere near the full spectrum of community support services needed to effectively practice comprehensive psychiatric rehabilitation.

100. Character-disordered young adults such as Patient E are particularly difficult to treat. Case managers who work with such patients need clinical supervision. Respondent had minimal formal psychiatric training and did not consult with professional colleagues. As a result, she took on more than she could handle witih patients such as E, did not know how to treat them, and tried to control them by yelling at and humiliating them.

101. The hearing committee strongly supports the concept of community psychiatry, properly implemented. Community psychiatry is not on trial in this case. Respondent is on trial. She attempted to use community psychiatry to bolster her case. She took issue with the Board for bringing a case against her and implied that she was being persecuted.

102. The hearing committee carefully reviewed the journal articles she offered into evidence. The hearing committee understands the community psychiatry model. Even when measured against that model, which respondent would have this committee apply, her conduct was unprofessional.

103. Taken together, the journal articles submitted by respondent provide standards for community psychiatry, including program evaluation, peer review, use of a team approach, and coordination with support agencies. These standards apply equally to comprehensive psychiatric rehabilitation, which is what respondent calls her practice model. These standards were wholly lacking in respondent's case.

104. The journal articles submitted by respondent on the

use of psychiatric medications covered a research time span of 30 years. During that time span, certain points remained constant: the need for more controlled studies in the use of medication for child psychiatric disorders, the difficulty of diagnosing major psychiatric illness in young children, the need to gather and integrate information from a variety of sources before arriving at a clinical diagnosis, the lack of Federal Drug Administration (FDA) approval for use in children of many of the psychotropic drugs used in adults, the need to carefully monitor patients prescribed psychotropic drugs, and the potential such drugs have for adverse and toxic side effects.

105. The journal articles submitted by the parties provide standards for the medication of children with psychiatric disorders, beginning with thorough clinical training and including formulation of a comprehensive treatment plan, frequent patient assessment, and consistent monitoring and follow-up. These standards were wholly lacking in respondent's case.

Length of Respondent's Testimony

106. The task of exercising reasonable control over the mode and order of interrogating witnesses and presenting evidence falls to the hearing committee.

107. There were 16 full days of hearings in this case. The hearing committee reserved four full days for respondent's testimony. This means that respondent was permitted to avail herself of fully one quarter of the total time spent in hearings, in which to present her case. The hearing committee also afforded both parties liberal cross-examination, so that respondent was able to elicit a great deal more evidence in the other 12 days of hearings.

108. Moreover, the parties were allowed to file additional written testimony, including both direct and cross-examination, after the hearings. The parties were granted liberal extensions of deadlines for these filings to accommodate their schedules. These arrangements afforded respondent ample opportunity to present her case.

Gross Failure to Uphold the Standard of Care

109. Although the Vermont Supreme Court has rejected the concept of "gross" in the negligence standard as being misleading and suggesting to the trier of fact a standard of care higher than ordinary care, the concept remains embedded in the Medical Practice Act.

110. Gross failure to uphold the standard of care means that respondent's behavior was even more egregious than a simple failure to uphold the standard of care. The term "gross failure"

distinguishes between grave acts of negligence and less serious acts of negligence.

Count I (Patient A)

111. Patient A was respondent's psychiatric patient in May, 1989. Patient A had a long psychiatric history which included many psychiatric hospitalizations. Patient A had been diagnosed as having a schizophrenic disorder and also had significant anxiety.

112. In 1990, respondent concluded that Patient A's financial problems were a primary cause of anxiety for the patient. On May 24, 1990, respondent took over Patient A's financial affairs by opening a trustee checking account for her with the Vermont Federal Bank. Respondent named herself as trustee of the account and was its only authorized signatory. Respondent had the bank print checks which read "Annette Lynch Trustee for [Patient A]", with respondent's address appearing below the imprint. Respondent wrote several checks on this account.

113. By July 23, 1990 (the date of Patient A's complaint to the Board), the payee arrangement with Patient A was not working very well at all. Delays at the bank in receiving or crediting deposits and in issuing checks led Patient A to believe that respondent was stealing her money. Respondent blames Patient A for jumping to a "paranoid conclusion" that respondent was stealing her money.

114. In fact, Patient A's belief illustrates one of the problems with a psychiatrist entering into this sort of arrangement with a seriously mentally ill patient. The patient is likely to misunderstand or misinterpret events.

115. Respondent and Patient A engaged in heated arguments over the management of the trustee account, during which both used profanity and yelled at each other. According to respondent, there was even an incident where Patient A "was very heated and . . . zoomed into the office with the complaint that I was stealing from her."

116. Respondent's stint as Patient A's payee lasted two or three months and did not have a good outcome. Patient A became angry with the arrangement, became convinced that respondent was stealing her money, was upset by respondent's rough treatment of her, and filed a complaint with the Board.

117. Respondent admitted that there can be a boundary problem with taking over a patient's finances: it interjects into the situation an additional relationship involving a touchy subject (money) that can make it more difficult for the

psychiatrist to provide effective therapy.

118. Respondent also admitted that straightening out patient finances is not a good use of a psychiatrist's time. Such a task is too burdensome and time-consuming for a psychiatrist. A better solution would be to find someone else to do it less expensively.

119. During the course of therapy with Patient A, respondent also bought personal items from Patient A when Patient A was having financial difficulties.

120. On repeated occasions, respondent violated the standard of care in treating Patient A. Respondent disregarded fundamental principles of physician-patient boundaries and created an inappropriate financial dependency between Patient A and herself by taking over the management of Patient A's financial affairs and purchasing personal items from her. In addition, respondent's actions compromised the therapeutic relationship she had with Patient A.

121. Respondent also repeatedly violated the standard of care in that she became involved in heated arguments with Patient A about therapeutic issues and management of the patient's trust account, yelled at Patient A, and used profanities in her interactions with the patient.

Count II (Patient B)

122. Patient B was a psychiatric patient of respondent's from January through September 1989. For many years, Patient B had suffered from a very severe manic depressive disorder. She had many psychiatric hospitalizations and episodes of mania and depression. Patient B had also been out of work for a long time before becoming respondent's patient.

123. Patient B was hospitalized at Vermont State Hospital in Waterbury for psychiatric problems in March or April and again in September 1989.

124. Following Patient B's April hospitalization, respondent asked Patient B to work for her, doing mostly clerical work. Respondent characterized this as "sheltered work" to train Patient B eventually to return to work in the community. However, respondent never contacted local social service agencies to see whether they might be able to provide appropriate work for Patient B.

125. Patient B routinely filed confidential documents relating to other patients of respondent's. Patient B had the opportunity, or could have been perceived by other patients as having the opportunity, to read their files.

126. As part of her duties, Patient B copied documents and ran various errands for respondent. Running errands included such tasks as picking up prescriptions and transporting patients. During the time that she was employed by respondent, Patient B was also respondent's patient.

127. Because, by respondent's own admission, it is difficult to devise enough errands for someone to do in a small office, respondent would sometimes add some personal errands for Patient B to run, such as picking up respondent's dry cleaning, and purchasing respondent's eyeglasses and makeup.

128. Patient B was supposed to be paid for her work. Often, respondent did not pay Patient B on time, and Patient B would have to go back to the office three or four times to get her paychecks. This left Patient B frustrated, aggravated and angry. Patient B also had trouble getting reimbursed for expenses she incurred. Respondent had a history of not paying her employees promptly, including a part-time music therapist and a part-time art therapist.

129. On at least one occasion, Patient B and respondent had a heated argument over respondent's failure to pay Patient B promptly. On that occasion, Kelly Lyon-Haydon, a part-time music therapist employed by respondent, overheard respondent yelling in her office at Patient B about the issue of payment. Patient B asked to pick up her paycheck, but respondent refused to give it to her. Patient B left the office very upset.

130. At one point, respondent had Patient B use her own Medicaid card to get a prescription for Prozac. When Patient B returned to respondent's office with the medication, respondent took it from her, and Patient B did not see what she did with it. The prescription was written in Patient B's name, but Patient B worried that respondent was having her use her Medicaid card to buy Prozac for another patient. This episode greatly upset Patient B, because she was afraid she would get into trouble for buying someone else's medication with her Medicaid card.

131. Respondent stated that she put the Prozac in her office drug closet for dispensing to Patient B later but admitted that this might not have been clear to Patient B. What respondent actually did with the Prozac Patient B purchased is unimportant in this context. The point is that by having Patient B use her Medicaid card to buy the medication and by taking the medication from Patient B and not explaining to her what she was going to do with it, respondent caused Patient B to experience fear and anxiety over the outcome of running the errand for respondent. This incident shows the problems that can arise when a patient with a serious mental illness is given this kind of task in a private practice setting with few resources.

132. Respondent claimed that she did not "employ" Patient B but rather instituted a therapeutic rehabilitation plan for which Patient B received a "stipend" as standard procedure. Regardless of what it is called, such an arrangement raises boundary issues, as respondent admitted. Such an arrangement makes the therapeutic relationship more complex than it needs to be and raises the issue of whom the arrangement is benefitting,--the therapist or the patient?

133. Respondent repeatedly violated the standard of care with respect to Patient B by allowing Patient B access to confidential information about other patients and by engaging in at least one very heated argument with the patient over respondent's failure to pay the patient in a timely way.

134. It also was a violation of the standard of care for respondent to have sent Patient B to a pharmacy with a prescription written in Patient B's name, having Patient B use her Medicaid card to have the prescription filled, having Patient B turn the prescription over to respondent without explaining what would happen with the medication, and causing Patient B to experience fear and anxiety that she had used her Medicaid card illegally.

135. Respondent also violated the standard of care by employing Patient B in an exploitative and irresponsible fashion. In addition to employing Patient B to run errands for her, respondent once sent Patient B and another patient to Burlington in the other patient's car to deliver a package. The other patient became intoxicated during this errand, and Patient B had to drive the other patient's car back to Rutland in bad weather. Patient B managed to figure out how to drive the other patient's car and to get both the other patient and herself back to Rutland, but the episode was extremely stressful and anxiety-provoking for Patient B.

Count III (Patient C)

136. Patient C, a manic depressive, began treatment with respondent in January 1989. Patient C had been diagnosed as having bipolar disorder and was taking lithium, Trilafon, and Halcion when she started seeing respondent. Patient C was too sick to be interacting with other patients in the settings into which respondent inserted her.

137. Patient C had been hospitalized just before commencing treatment with respondent. During the course of her treatment by respondent, she was hospitalized five fimes, four of which were for depression or suicidal ideation. During her treatment by respondent, Patient C was given numerous medications including lithium, Halcion, Prozac, Xanax and Synthroid. Respondent changed Patient C's medications frequently.

138. In the late spring or early summer of 1989, respondent introduced Patient C to Patient E. Respondent believed that Patient C could assist Patient E in learning better social behavior.

139. At one point, Patient E moved in with Patient C and her young son. Respondent was responsible for and arranged for this highly unsatisfactory and unsuitable living arrangement. Although respondent denied that she arranged for this, the testimony of Patients C and E and of Witness G (Patient E's mother) was consistent about respondent's role in arranging this living situation.

140. During Patient E's stay with her, Patient C at times found Patient E to be dazed and incoherent. At one point, Patient E fell asleep in Patient C's bathtub. She did not respond when Patient C came to the door of the bathroom. Patient C entered the bathroom and found Patient E's head submerged underwater. Patient C pulled Patient E's head out of the water and, not knowing whether Patient E was alive or not, quickly called a neighbor who came over and helped to get Patient E out of the tub. Patient E appeared to be heavily under the influence of drugs. This episode was extremely upsetting and frightening for Patient C.

141. Patient C expressed her concerns to respondent that Patient E might be over-medicated. Respondent assured Patient C that Patient E needed the medication she was receiving.

142. Some time after Patient E moved in with Patient C, a social worker from SRS came to the house and told Patient C that Patient E would have to leave or Patient C would lose custody of her young son. Arrangements were made for Patient E to leave immediately. Later, Patient C learned that Patient E had been accused of some form of child molestation or abuse.

143. Almost immediately after Patient C got out of the hospital on one occasion, and while Patient C was her patient, respondent employed Patient C to visit and assess another psychiatric patient, Patient D. Patient D was an elderly nursing home resident who was a double amputee. Patient C was told by respondent that she was to serve as a "friendly visitor" for Patient D and was to make sure that Patient D was comfortable and happy. Respondent did not indicate to the nursing home staff that Patient C was her psychiatric patient. This meant that the nursing home staff did not have the information necessary to make an informed decision about the propriety of allowing Patient C to visit Patient D.

144. Respondent introduced Patient C to Patient D as respondent's assistant. On at least one occasion, Patient C was

introduced by respondent to Patient D as being respondent's employee.

145. Respondent told Patient C that she would serve as a "social worker" for some of respondent's other patients.

146. Patient C was expected to report to respondent concerning her visits with Patient D. Respondent made Patient C draft and re-draft one particular report repeatedly, so that Patient C would see what it took to go to college or to be a social worker. Patient C dreaded working on the report and became very upset, because she could not seem to write the report in a way that satisfied respondent.

147. Respondent did not use this as an opportunity to explore why Patient C dreaded writing the report but, rather, handled the report in a way that damaged the therapeutic relationship and resulted in Patient C's feeling like a failure.

148. At one point, respondent became actively involved in attempting to find alternative living arrangements for Patient D and asked Patient C to allow Patient D to live in her home. At respondent's suggestion, modifications were made to Patient C's home so that it would be wheelchair-accessible. These modifications were done at Patient C's own expense.

149. These arrangements were made even though Patient D had family members who lived just a few streets away. Those family members would not have Patient D live with them because of her difficult personality.

150. When Patient C met with these family members, she dressed professionally, brought a briefcase, and told them she was respondent's associate. She did not tell them that she also was a patient of respondent's because she did not want to frighten them. Respondent did not tell the family members that Patient C was a patient. Patient D's family agreed to have Patient D move out of the nursing home and in with Patient C.

151. This is an example of how respondent's unrealistic plans for patient rehabilitation quickly got out of hand. After respondent encouraged Patient C to believe that she could function as an associate or social worker, Patient C began introducing herself to others as such, thereby misleading them and inducing them to allow their elderly relative to live with her.

152. Patient D stayed at Patient C's house less than a month. During this time, Patient C administered medications prescribed by respondent to Patient D. The fact that Patient C, who was seriously mentally ill, dispensed medications to Patient D did not concern respondent.

153. Patient C found Patient D to be more difficult than she expected. Patient D was unpredictable, explosive, tantrum-oriented, unreasonable, and had crying spells. On more than one occasion, Patient C expressed concern about this situation to respondent, but respondent did not see the need to change Patient D's placement.

154. At one point, Patient D's family members became concerned that Patient D's money was missing. The family questioned respondent about this, and respondent angrily told Patient C that she "damn well better" find the money. Patient C found the money later inside a pillow, where Patient D had hidden it.

155. Eventually, Patient D was removed from Patient C's home. This was a major relief to Patient C. Respondent had criticized her for her care of Patient D and had made her feel hopeless.

156. In an attempt to absolve herself from any wrongdoing regarding Patient D, respondent told Patient C to write a statement that unbeknownst to respondent, Patient D was removed from the nursing home and brought to Patient C's home. Patient C felt that this statement was a lie but that she had to write it or her relationship with respondent would be over.

157. As part of her duties, Patient C filed records of other patients in respondent's office. Patient C did this while she was respondent's patient. Patient C had the opportunity, or could have been perceived by other patients as having the opportunity, to read their files.

158. Respondent paid Patient C $75 a month, even though Patient C sometimes worked as much as 40 hours a week. When Patient C fell behind on her therapy bill, respondent had her work off the bill by doing clerical work in the office. According to the journal articles submitted by respondent, this type of barter is generally frowned upon in psychiatry.

159. "Different forms of barter involve different boundary issues. . . . [S]ervices that involve contact with confidential records . . . may present problems." Resp. exh. A23 at 1447. (Gabbard and Nadelson, Professional Boundaries in the Physician-Patient Relationship, 273 Journal of the American Medical Association 1445, 1447 (1995)).

160. "Barter is confusing and probably ill-advised today." Resp. exh. A24 at 192. (Gutheil & Gabbard, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, 150 American Journal of Psychiatry 188, 192 (1993)).

161. "The Exploitation Index . . . is a questionnaire designed by Epstein and Simon (1990) to alert practitioners to slippery-slope behaviors that might prove counterproductive to treatment goals." One of the questions in the Exploitation Index is: "Do you accept a medium of exchange other than money for your services?" Resp. exh. A27 at 417-418. (Frick, Nonsexual Boundary Violations in Psychiatric Treatment, in 13 Review of Psychiatry 417-418 (J. Oldham & M. Riba eds. 199-)).

162. "The following boundary guidelines for psychotherapy help maintain the integrity of the treatment process: . . . Establish a stable fee policy." Resp. exh. A25 at 147. (Simon, Treatment Boundaries in Psychiatric Practice, in Principles and Practice of Forensic Psychiatry 147 (R. Rosner ed. 1994)).

163. On occasion during therapy sessions, respondent became upset with Patient C. Her face got red, she yelled at Patient C, and she used profane language in addressing her. Respondent's actions left Patient C frightened of her and also fostered in Patient C a low sense of self-worth. Respondent's conduct engendered in Patient C the belief that she deserved all of the yelling, screaming, and abuse that respondent heaped upon her.

164. On one occasion, respondent shook Patient C by the shoulders. On another occasion, she struck Patient C in the face. Patient D's sister-in-law saw the red mark where respondent had slapped Patient C's face, when Patient C went to her house immediately after the incident. Being slapped by respondent was especially upsetting to Patient C in light of her past history of physical abuse at the hands of others.

165. On another occasion, respondent hit Patient C on the wrist and grabbed her to prevent her from leaving the office.

166. On yet another occasion while she was respondent's patient, Patient C cut her wrists in a suicide attempt. In discussing this incident with Patient C, respondent disgustedly referred to it as a "Hollywood display of wanting to die."

167. Respondent acknowledged that it was difficult for Patient C to maintain appropriate personal boundaries, yet respondent arranged situations of extreme difficulty for C, in which maintaining appropriate personal boundaries was very important. A prime example of this was having Patient C act as a "friendly visitor."

168. Patient C's relationship with respondent ended after an incident when, as a result of a blackout induced by Halcion prescribed by respondent, Patient C found herself in Grand Central Station in New York City. She was removed from the station and admitted to a psychiatric hospital in New York. As a result of her treatment with respondent, Patient C is now left

with a sense of great anxiety about interacting with mental health professionals.

169. Respondent's conduct with respect to Patient C showed repeated violations of the standard of care. An especially serious breach of the standard of care occurred when respondent slapped the patient across the face. Respondent's conduct in this regard was particularly egregious because the patient had a long history of physical and sexual abuse.

170. Respondent violated the standard of care by yelling at Patient C and using profanity.

171. Respondent violated the standard of care by telling Patient C that she would be her assistant and social worker and by allowing her access to confidential information concerning other patients. The standard of care was also violated by respondent's blurring the distinction between physician and patient on one hand and employer and employee on the other.

172. Respondent violated the standard of care by facilitating a situation where Patient C took Patient D home with her. This living arrangement was extremely difficult and stressful for Patient C and resulted in, among other things, Patient C's feeling coerced into drafting a false written statement to absolve respondent. The standard was also violated because the matching of Patient D (who was an elderly, obstreperous, demanding bilateral amputee who needed much care) with Patient C (who was having difficulties managing her own life and who had a young son at home) was totally inappropriate.

173. Respondent violated the standard of care by humiliating and degrading Patient C.

174. Respondent violated the standard of care by facilitating the arrangement whereby Patient E (who was difficult and unmanageable) moved in with Patient C (who was seriously mentally ill). Again, the pairing of these two seriously ill patients in a living arrangement was totally inappropriate.

Count IV (Patient E)

175. Patient E began seeing respondent as her psychiatrist when she was very young and has continued to be respondent's patient intermittently for the past nine years. Patient E had a very complex and extensive psychiatric history. She also had a long history of psychiatric hospitalizations and oppositional, willful, and destructive behavior. Patient E was at times violent, abusive to others, and suicidal. While she was Patient E's therapist, respondent prescribed numerous medications for Patient E.

conflict that detracted from the therapeutic relationship.

193. Respondent violated the standard of care by yelling and swearing at Patient E and yelling at the patient's mother, Witness G.

194. Failing to keep Patient E's medical records confidential violated the standard of care to which a reasonable, prudent physician would adhere.

Count V (Patient D)

195. Patient D, an 82-year-old double amputee, was another of respondent's patients. Patient D exhibited unstable moods, outbursts of anger, aggressive behavior, and depression. When respondent began seeing her, Patient D lived in a nursing home. Respondent's diagnosis of Patient D was early dementia and possible bipolar disorder. Throughout the time that respondent was Patient D's physician, Patient D's brother and sister-in-law were extensively involved in Patient D's care and life. Patient D remained respondent's patient until her sister-in-law wrote respondent a letter in February 1990, terminating that relationship.

196. While Patient D was living at the nursing home, respondent became dissatisfied with the services that Patient D was receiving there. Respondent actively undertook to find alternative living arrangements for Patient D. Ultimately, respondent arranged to have Patient D move in with Patient C, another of respondent's patients who had been assigned to be Patient D's "friendly visitor". This arrangement did not work well for either Patient C or Patient D. Eventually, Patient D was taken by ambulance from the home of Patient C and was admitted to the Rutland Regional Medical Center on August 23, 1989.

197. While Patient D was at the Rutland Regional Medical Center, she became more unruly and depressed. Hoping to help change this behavior, respondent took Patient D from the hospital to respondent's home on an overnight pass on the evening of September 30, 1989. Respondent brought Patient D back to the hospital on October 1, 1989. Respondent neglected to contact any of Patient D's family members before taking Patient D overnight to her home.

198. At first, Patient D's spirits improved, and she talked excitedly to the hospital staff about going out on another pass with respondent. However, when respondent subsequently took Patient D home again on an overnight pass, the visit did not go well.

199. Patient D's sister-in-law learned about the visit when

Patient D, who was very agitated, called her sister-in-law from respondent's home and asked her to come and get her. After this event, Patient D's sister-in-law attempted to call respondent to speak with her about taking Patient D home. Respondent did not return the sister-in-law's phone calls.

200. One of Patient D's visits to respondent's home occurred on the evening before a hearing to determine guardianship of Patient D. On the morning of the guardianship hearing, respondent returned Patient D to the hospital. When Patient D's sister-in-law came to get Patient D for the hearing, Patient D was extremely agitated and struck her sister-in-law. The sister-in-law asked the staff why Patient D was upset. The hospital staff told the sister-in-law that respondent had taken Patient D home with her the night before. The sister-in-law was surprised because she had seen Patient D the day before and no mention was made at that time that respondent was going to have Patient D spend the night at her home again. Respondent again neglected to notify any family member before taking Patient D home with her.

201. After spending the night with respondent at her home, Patient D was rude, swore at the judge, and slammed a chair in the courtroom at the guardianship hearing. It was unusual for Patient D to be so irate in public.

202. The day after her return from respondent's home, Patient D used abusive language and hit the hospital staff.

203. That same day, the sister-in-law instructed the staff at the hospital that she would permit no more overnight stays for Patient D with respondent without prior approval from the sister-in-law. The sister-in-law also requested a change of physician.

204. Based on the observations of her sister-in-law, Patient D's behavior was worse after her overnight visits with respondent than before the visits. In addition, after acting out at the hospital a day after returning from respondent's home, hospital staff notes indicated that Patient D told the staff, "Every time I go on a pass, this happens."

205. Respondent admitted that she took Patient D overnight to her home on two occasions. Respondent also admitted that, on one of these occasions, she did not call the sister-in-law before taking Patient D home overnight.

206. Respondent failed to contact the Office on Aging, or any other respite care provider, to find alternative care for Patient D.

207. In May 1990, respondent temporarily lost her hospital privileges at the Rutland Regional Medical Center because of

176. During Patient E's treatment, respondent facilitated the placement of Patient E in Patient C's home.

177. By placing Patient E in Patient C's household, respondent jeopardized the health, safety, confidentiality, and welfare of both patients. At one point, Patient C found Patient E submerged and unconscious in Patient C's bathtub. Patient C needed the help of a neighbor to remove Patient E from the bathtub because of Patient E's large size.

178. Patient C's young son was also placed in jeopardy in that there had been a previous allegation that Patient E had molested a young child. When SRS discovered that Patient E was in Patient C's home, they threatened to take Patient C's son away from her unless Patient E left immediately. Patient E was embarrassed and upset when she had to be removed from Patient C's home.

179. Respondent's testimony about the propriety of Patient E living with Patient C was contradictory and diminished her credibility. On one hand, respondent claimed to be somewhat disturbed at the living arrangement because, according to her, it had occurred without anyone knowing about it. She also admitted that there was evidence that Patient E was drinking alcohol while at Patient C's home. On the other hand, respondent seemed to believe that it was perfectly appropriate for Patients C and E to live together, because she testified with a smile that they "had a ball" while they lived together.

180. At one point, respondent invited Patient E to stay overnight at her house. During the visit, Patient E mowed respondent's lawn and developed blisters on her hands as a result. Patient E believed that respondent would pay her $30 to mow the lawn. Respondent did not pay Patient E for mowing the lawn, which made Patient E very upset. Patient E felt that she had been treated like a "slave dog."

181. In this instance, respondent facilitated a situation in which a seriously mentally ill patient came to believe that respondent would do something (i.e., pay $30 for mowing the lawn) and then became very upset, confused, and angry when respondent did not behave as the patient expected.

182. Patient E was uncomfortable with the manner in which respondent ran her practice, because of the lack of confidentiality. Patients had access to other patients' files. At one point, another patient tried to blackmail Patient E with information from her files.

183. During the period in which respondent was Patient E's therapist, Patient E's mother (Witness G) petitioned the Rutland Probate Court for guardianship over her daughter, Patient E. A

hearing was held on the guardianship petition on May 19, 1993.

184. At the May 19, 1993, guardianship hearing, respondent told the court that she had discussed guardianship and SSI payee issues with Patient E in the past and that she would agree to act as Patient E's guardian, despite the fact that she was Patient E's therapist. Respondent was aware that this created a conflict of interest, because she told the court that she was concerned about being the child's therapist and guardian at the same time.

185. Despite this conflict of interest, respondent agreed to serve and was appointed guardian of Patient E.

186. When respondent was appointed guardian of Patient E, Patient E's mother was angry and distressed. She did not want respondent to be Patient E's guardian because she did not trust respondent. Respondent never actually served as Patient E's guardian, and guardianship of Patient E was subsequently transferred to Witness G on June 23, 1993.

187. After the June 23, 1993 hearing, when guardianship of Patient E was transferred to her mother, respondent yelled at the mother (Witness G), who was standing on the courthouse steps with other people who had attended the hearing.

188. On other occasions during her treatment of Patient E, respondent yelled and swore at Patient E.

189. Respondent's conduct with respect to Patient E showed repeated violations of the standard of care.

190. By agreeing to have herself appointed guardian for Patient E, respondent violated the standard of care. She was willing to create an inappropriate financial and psychological dependence between Patient E and herself. By breaching the physician-patient boundaries, respondent created a situation that was not therapeutic. This failure to respect and limit boundaries caused harm to the physician-patient relationship.

191. By facilitating the placement of Patient E in Patient C's home, respondent violated the standard of care. Patient E was difficult and unmanageable, exhibiting a cyclic, aggressive, sometimes out-of-control behavior pattern. Patient C was a manic depressive. An ordinary, reasonable psychiatrist would not have facilitated an arrangement in which these two patients lived together.

192. By facilitating the situation in which Patient E mowed her lawn, did not get paid for it, and then became angry and confused, respondent exploited Patient E and violated the standard of care. Respondent's conduct mixed an employment component into the therapeutic relationship and created a

these professional boundary violations related to Patient D and several other patients.

208. According to respondent's own expert witness on boundary issues, Dr. Coyne, taking patients home is currently not in vogue in psychiatry, precisely because problems develop. A patient taken home by a psychiatrist may have unrealistic expectations for the relationship and may be disappointed when those expectations are not met. Taking a patient home is far too difficult for most psychiatrists even to want to do it.

209. By taking Patient D home overnight with her, respondent breached accepted physician-patient boundaries and repeatedly violated the standard of care of an ordinary, prudent physician in similar circumstances.

210. Taking a patient home creates the false and impractical expectation on the part of the patient that the physician will come and save the patient. This false and impractical expectation creates the potential for harm to the patient.

211. In this case, Patient D's initial high spirits after the first home visit turned into abusive, disruptive, and destructive behavior after a subsequent home visit.

Count VI (Patient H)

Count VI of the Amended Specification of Charges was voluntarily withdrawn by petitioner.

Count VII (Patient I)

212. Patient I was a girl approximately two years, eight months of age when respondent first saw her for evaluative purposes at Rutland Mental Health Services on February 11, 1988. Patient I was in foster care and had been referred to Rutland Mental Health Services by SRS, because her foster mother complained that she slept poorly, was hyperactive, overate, and ate inedible substances.

213. When respondent saw Patient I on that first visit, she obtained Patient I's history, observed the child, requested Patient I's medical records, and scheduled a second appointment for February 25.

214. At the second appointment, respondent observed Patient I and diagnosed her as having a bipolar disorder. As a result of the two visits, respondent formulated an evaluation, assessment, and treatment plan that included prescription of mood-stabilizing medications such as lithium or Tegretol.

215. Respondent called Patient I's pediatrician, Dr. Robert Hession, to discuss the relative merits of prescribing lithium or Tegretol for Patient I. This was the only consultation with another physician that respondent obtained while treating Patient I.

216. Respondent's psychiatric evaluation of Patient I was significantly weak. In the evaluation, respondent neglected to discuss how Patient I got to the point of exhibiting the observed behavior problems. The evaluation did not discuss factors other than a serious, chronic, debilitating psychiatric illness (bipolar disorder) that may have caused or contributed to Patient I's behavior. A discussion of possible other contributing factors is called a "differential diagnosis." Respondent's evaluation contained no differential diagnosis for Patient I.

217. The symptomatology and history of Patient I's case required a differential diagnosis. Patient I was in foster care and had a history of possible abuse. The most common presentation of symptoms such as Patient I exhibited is early childhood trauma. Another diagnosis consistent with Patient I's symptoms (sleep disruption, hyperactivity, emotional lability) is early separation anxiety, or some type of medical illness.

218. "A borderline personality disorder should also be included in the differential diagnosis and is the most difficult to differentiate from the manic-depressive variant syndrome of childhood." Resp. exh. A183. (Potter, Manic-depressive Variant Syndrome of Childhood, 22 Clinical Pediatrics 495, 497 (1983)).

219. "It is rare for a diagnosis of mania to be made before age 7 . . . ." Resp. exh. A183. (McDaniel, Pharmacologic Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 67 (1986)).

220. "[A]lthough the occurrence of mania in children is now acknowledged by most workers, clear-cut cases are uncommon before age 12 years . . . . It is relatively difficult to establish an accurate diagnosis of mania during the first episode. Mania occurs in both children and adolescents, but it is rare in childhood." Resp. exh. A183. (Year Book of Psychiatry and Applied Mental Health 109-110 (D. Freedman, J. Talbott, R. Lourie, H. Meltzer, J. Nemiah & H. Weiner eds. 1984)).

221. "Our knowledge of psychotropic drug effects in children and adolescents is still inadequate for a rational and consistent clinical approach. . . . Prior to any drug therapy it is essential that a detailed baseline clinical assessment be undertaken. Assessments during therapy must be frequent, especially during the initial phases. . . . Information obtained from different sources (child, parents, teachers) must be

integrated." Resp. exh. A183. (Treatment Strategies in Child and Adolescent Psychiatry 134-135 (J. Simeon & H. Ferguson eds. 1990)).

222. "There is no substitute for a well-trained clinician who does a comprehensive assessment. This includes interviewing the child with the family, the child alone, and the family alone . . . and then integrating all the information to arrive at a clinical diagnosis." Pet. exh. 61. (Weller, Weller & Fristad, Bipolar Disorder in Children: Misdiagnosis, Underdiagnosis, and Future Directions, 34 Journal of the American Academy of Child & Adolescent Psychiatry 709, 712 (1995)).

223. After observing Patient I on two occasions, an ordinary reasonable physician would not have diagnosed her with bipolar disorder, particularly since diagnosis of bipolar disorder in a child as young as Patient I is extremely rare. Respondent lacked the solid, reliable information upon which to base such a diagnosis. However, respondent forged ahead with the diagnosis. The diagnosis then drove the treatment exclusively in the direction of pharmacological remedies.

224. The first drug respondent prescribed for Patient I was Tegretol. Tegretol is an anti-convulsant medication used by neurologists to treat seizures. It has also been found to have some beneficial effect in treating mania in adults and adolescents. Even respondent's own expert, Dr. Rabinovich, stated that it is unusual for Tegretol to be prescribed for bipolar disorder for a child as young as Patient I.

225. Tegretol is a powerful drug. The Physicians' Desk Reference carries the following warning in bold print:

"Serious and sometimes fatal abnormalities of blood cells . . . have been reported following treatment with Tegretol. . . . Early detection of hematologic change is important since, in some patients, aplastic anemia is reversible. Complete pretreatment blood counts, including platelet and possibly reticulocyte and serum iron, should be obtained. Any significant abnormalities should rule out use of the drug. These same tests should be repeated at frequent intervals, possibly weekly during the first three months of therapy and monthly thereafter for at least two to three years. The drug should be stopped if any evidence of bone marrow depression develops. Patients should be made aware of the early toxic signs and symptoms of a potential hematologic problem, such as fever, sore throat, ulcers in the mouth, easy bruising, petechial or purpuric hemorrhage, and should be advised to discontinue the drug and to report to the physician immediately if any such signs or symptoms appear."

226. An ordinary, reasonable physician would have ordered these blood tests for a child for whom Tegretol had been

prescribed and would have included the results of the tests in the patient's medical record. Respondent did not follow this procedure with Patient I. The tests were not performed on Patient I and therefore, no results were recorded in her medical record.

227. Having prescribed Tegretol for Patient I, respondent failed to provide adequate monitoring and follow-up. Patient I's foster mother and SRS caseworker could not get in touch with respondent when Patient I became too sleepy on the dose of Tegretol she was receiving. Forced to act on their own, they cut Patient I's afternoon dosage in half.

228. Patient I's sleep problems continued, and she had nightmares. Over a period of approximately three weeks, respondent recommended decreasing and then increasing Patient I's Tegretol dose.

229. Patient I's SRS caseworker continued to have difficulty contacting respondent about Patient I.

230. Throughout the spring and summer of 1988, Patient I's problem behaviors continued, including eating feces, drinking out of the toilet, and hitting, scratching, and biting others.

231. By the end of August, respondent was prescribing both Tegretol and lithium for Patient I.

232. Lithium is a powerful drug. The Physicians' Desk Reference carries the following warning for lithium:

"Lithium toxicity is closely related to serum lithium levels, and can occur at doses close to therapeutic levels. Facilities for prompt and accurate serum lithium determinations should be available before initiating therapy."

233. Treating a child or adult with lithium and Tegretol simultaneously and concurrently is extraordinarily risky. The risk to the patient is compounded if the prescribing physician cannot easily be contacted, as was the case with respondent.

234. "Particular attention . . . should be paid to the suppressant effect of lithium on the thyroid gland and possible changes in calcium metabolism. Lithium may lower the seizure threshold . . . . Thyroid and renal functions should be monitored throughout therapy." Resp. exh. A183. (Potter, Manic-depressive Variant Syndrome of Childhood, 22 Clinical Pediatrics 495, 498 (1983)).

235. "Of concern . . . are possible renal and thyroid toxic reaction with lithium carbonate." Resp. exh. A183. (Campbell, Small, Green, Jennings, Perry, Bennett & Anderson, Behavioral

Efficacy of Haloperidol and Lithium Carbonate, 41 Archives of General Psychiatry 650, 655 (1984)).

236. "Lithium's effect, if any, on growth, development, and maturation has not been established. . . . The effects of lithium, if any, on children's academic function remain to be detailed." Resp. exh. A183. (1 Comprehensive Textbook of Psychiatry/IV 1796 (H. Kaplan & B. Sadock eds. 1985)).

237. Regarding lithium, "prudence would dictate . . . periodic screening of thyroid . . . and renal function . . . . The need, safety and dosage in children has yet to be determined." Resp. exh. A183. (Cytryn & McKnew, Treatment Issues in Childhood Depression, 15 Psychiatric Annals 401, 403 (1985)).

238. "[M]ore studies will be needed to . . . confirm the safety [of lithium] for the use in children. At the time of this writing [1986], the package insert for lithium does not recommend its use in children under the age of 12 years." Resp. exh. A183. (McDaniel, Pharmacologic Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 70 (1986)).

239. "At the present time, the only two clinical situations for which routine monitoring of drug levels in blood is recommended are (1) the measuring of plasma levels of antidepressant in children with major depression and (2) the careful monitoring of serum lithium levels . . . ." Resp. exh. A183. (5 Basic Handbook of Child Psychiatry 402 (J. Call, R. Cohen, S. Harrison, I. Berlin & L. Stone eds. 1987)).

240. "Detailed knowledge about the efficacy and side effects of psychotropic drugs in childhood and adolescent insomnia . . . awaits further controlled studies." Resp. exh. A183. (5 Basic Handbook of Child Psychiatry 472 (J. Call, R. Cohen, S. Harrison, I. Berlin & L. Stone eds. 1987)).

241. Concomitant administration of Tegretol and lithium may increase the risk of neurotoxic side effects.

242. By the end of September 1988, respondent had begun prescribing amitriptyline for Patient I. For approximately two weeks at the beginning of October, respondent was prescribing both lithium and amitriptyline for Patient I.

243. Amitriptyline is a tricyclic antidepressant. It affects the neurotransmitters in the brain. The 1987-1988 Physicians' Desk Reference carried the following warning for the drug: "Usage in Children--In view of the lack of experience in children, the drug is not recommended at the present time for patients under 12 years of age."

244. In a prefatory note to a 1973 journal article, the editor cautioned: "Although this article has been recommended for publication . . ., the Editor feels it necessary to stress extreme caution (1) in identifying any child as having a depressive illness and (2) in prescribing any medication for such a disorder. . . . Certainly all children who receive drug therapy on a continuing basis must be carefully monitored for evidences of toxicity and other side effects. The drug used in this study [amitriptyline] has not been approved for use in children less than 12 years of age." Resp. exh. A183. (Weinberg, Rutman, Sullivan, Penick & Dietz, Depression in Children Referred to an Educational Diagnostic Center: Diagnosis and Treatment, 83 Journal of Pediatrics 1065 (1973)).

245. A 1976 journal article submitted by respondent describes the cases of three children successfully treated with amitriptyline for mania or mania and depression. However, these children were all older than Patient I, ranging in ages from almost four to 11. The article also describes the case of a four-year-old girl who experienced a manic episode. Her symptoms were exacerbated by amitriptyline therapy. "Treatment of a subsequent depression with amitriptyline resulted in the reappearance of manic symptoms, which then disappeared after cessation of amitriptyline." Resp. exh. A183. (Weinberg & Brumback, Mania in Childhood, 130 Am. J. Dis. Child 380, 381-382 (1976)).

246. "Antidepressant drugs have been used for school-aged children since 1962 and for preschool children over 18 months of age since 1966. . . . However, there is consensus that when drugs are used, they must be part of a more comprehensive treatment plan that includes a focus on the child's environment, especially family and school. Unfortunately, most of the pharmacological intervention studies have methodological flaws that leave the results inconclusive." Resp. exh. A183. (Kashani, Husain, Shekim, Hodges, Cytryn & McKnew, Current Perspectives on Childhood Depression: An Overview, 138 American Journal of Psychiatry 143, 150 (1981)).

247. "The younger the child, the more responsive she or he will be to environmental changes alone." Resp. exh. A183. (Cytryn & McKnew, Treatment Issues in Childhood Depression, 15 Psychiatric Annals 401 (1985)).

248. "Considering the potential hazards of antidepressant drugs, especially to the cardiovascular system, caution is definitely indicated. . . . In clinical practice, one would be justified in the judicious use of tricyclic antidepressants in children in whom a depressive illness has been reliably diagnosed and who fail to respond to psychotherapy and environmental manipulation. Careful monitoring of side effects and only gradual increments in dosage are definitely indicated. Blood

pressure, pulse and EKG should be screened at regular intervals." Resp. exh. A183. (Cytryn & McKnew, Treatment Issues in Childhood Depression, 15 Psychiatric Annals 401, 402-403 (1985)).

249. "[T]he possible cardiotoxicity and reduced seizure thresholds as side effects of tricyclics in children require particular caution in the use of these drugs in pediatric populations. Selection of appropriate dosing regimen and careful monitoring of side effects is essential, as well as proper preparation of both child and parents for drug treatment." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 894 (1985)).

250. "[T]ricyclic intervention may be most effectively and safely carried out with severely depressed children as inpatients. Inpatient settings permit the consistent monitoring of compliance, vital signs, and plasma levels necessary for such careful treatment." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 897 (1985)).

251. "Until issues of indications for specific [antidepressant] drugs are settled, individual cases must be managed cautiously and systematically. Collection of adequate baseline data, conservative dosing regimens, careful titration to optimal dose, and standardized assessment procedures can be used to evaluate the efficacy of one or more medications with individual cases." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 903-904 (1985)).

252. "[O]f all the psychotropic drugs commonly used in children, the tricyclics call for the greatest caution." Resp. exh. A183. (Office of Technology Assessment, U.S. Congress, Children's Mental Health: Problems and Services 113 (1986) (quoting Conners & Werry)).

253. "The greatest concern with tricyclics is myocardial toxicity." Resp. exh. A183. (Gittelman & Koplewicz, Pharmacotherapy of Childhood Anxiety Disorders, in Anxiety Disorders of Childhood 199 (R. Gittelman ed. 1986)).

254. "The psychology of the developing child . . . poses two problems in psychopharmacologic research. The first has to do with the reliability of psychiatric diagnosis in children. The second has to do with the evaluation of drug response. Often, it is difficult to obtain useful introspective reports from small children. Additionally, rapid developmental changes make it difficult to describe a stable pattern of psychologic

malfunction over time. . . . Generally, it is accepted that an evaluation of the psychiatrically disturbed child or adolescent should include an assessment of the family, social, educational, and economic environment. This is both important diagnostically and in making treatment recommendations." Resp. exh. A183. (McDaniel, Pharmacological Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 66 (1986)).

255. "Because psychopharmacologic treatment of children may require lengthy periods of drug administration, it should only be undertaken when absolutely indicated. . . . If the disorder does not respond to nonpharmacologic treatment or if it is sufficiently severe to be dangerous or disruptive to child and family, the physician should not hesitate to initiate a trial of an appropriate drug, always with careful supervision and monitoring of dosage and effects." Resp. exh. A183. (McDaniel, Pharmacological Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 67 (1986)).

256. "[T]ricyclic antidepressants have the potential for adverse and toxic side effects." Resp. exh. A183. (5 Basic Handbook of Child Psychiatry 473 (J. Call, R. Cohen, S. Harrison, I. Berlin & L. Stone eds. 1987)).

257. "The importance of plasma concentrations, rather than dosages [of tricyclic antidepressants], cannot be overemphasized. . . . [I]t is not difficult to recognize the added importance of monitoring tricyclic plasma blood levels in children, who have even more physiologic factors influencing drug handling than do adults." Resp. exh. A183. (P. Trad, Infant and Childlhood Depression 385 (1987)).

258. "In adults, imipramine and the other tricyclics can cause serious adverse effects such as intracardiac conduction problems and impaired memory. Indications are that this class of drug can produce side effects in children similar to those seen in adults. Therefore, blood monitoring and caution are mandated while using tricyclics in prepubescent children." Resp. exh. A183. (P. Trad, Infant and Childlhood Depression 386 (1987)).

259. Patient I's foster mother could not reach respondent when Patient I's amitriptyline prescription ran out, so Patient I's SRS caseworker had to call respondent's office to get the prescription renewed.

260. By early October, respondent was prescribing lithium, Tegretol, and amitriptyline simultaneously for Patient I. The combination of drugs she was taking caused Patient I to experience visual and tactile hallucinations.

261. By early November, respondent had stopped prescribing lithium for Patient I but was still prescribing Tegretol and amitriptyline for her. Respondent had also added Mellaril to the child's drug regimen.

262. Because of the important possibility that many if not all of Patient I's aberrant behavior and neurological symptoms of disorganization and instability were caused by Tegretol and amitriptyline, the safest and most prudent course of action would have been stopping those medications rather than adding a third medication.

263. Other than an initial phone call to Dr. Hession to discuss prescribing Tegretol or lithium, respondent did not seek or obtain any consultations regarding the medications she prescribed for Patient I.

264. Respondent should have sought a consultation with another physician because of the extremely complicated nature of Patient I's case.

265. Patient I's caregivers continued to have difficulty contacting respondent. Respondent did not return phone calls or respond to requests for prescription refills. Because of these communication difficulties and respondent's unavailability, Patient I's foster mother and SRS caseworker met with another physician in November 1988 to obtain a second opinion about Patient I's treatment.

266. Throughout the fall and winter of 1988-1989, Patient I's caregivers continued to have difficulty contacting respondent, getting her to return their telephone calls, or making a scheduled home visit. Finally, Patient I's SRS caseworker wrote to respondent in March 1989 and asked her to withdraw from Patient I's care.

267. Respondent's treatment of Patient I constituted a gross violation of the standard of care.

268. Respondent failed to adequately evaluate Patient I with the range of tools and protocols expected to be used before arriving at any diagnosis. After observing the child during two office visits, respondent diagnosed Patient I as having a serious mental disorder.

269. Respondent failed to document her reasoning regarding Patient I's diagnosis, including data gathered and other potential diagnoses. Respondent's evaluation of Patient I contained no differential diagnosis and did not discuss factors other than a serious mental illness that could have contributed to the patient's behavior.

270. Respondent failed to articulate a cogent treatment plan for Patient I. She jumped to a diagnosis, which then drove the patient's treatment in the direction of pharmacological remedies.

271. Respondent prescribed potent antipsychotic and antidepressant drugs based on an inconclusive foundation. Respondent should have paid greater attention to Patient I's history and symptomatology and considered other possible diagnoses.

272. Respondent failed to provide adequate monitoring and follow-up for Patient I. Respondent did not undertake any clinical monitoring of Patient I (for example, blood tests, EKG's, or serum lithium levels), and Patient I's caregivers had extreme difficulty contacting respondent.

273. Aside from an initial telephone call to Patient I's pediatrician to discuss prescribing Tegretol or lithium, respondent failed to obtain consultations about the management of Patient I's complex case.

Count VIII (Patient J)

274. Patient J was a boy two years, nine months old when he was first treated by Sheila Conroy and respondent in May 1992. Respondent sat in on some of Ms. Conroy's sessions with Patient J for a few minutes at a time and informally observed the child.

275. Patient J's mother, Patient K, completed respondent's standard "student health history" form for her son, providing checklists and short answers about Patient J's medical history and behavior. The form asked many questions not applicable to a preschool child such as Patient J. This was the only assessment tool, other than brief informal observations and information relayed by Ms. Conroy, that respondent used to evaluate Patient J.

276. Ms. Conroy, who, by her own admission, takes "very poor notes," made brief written notes about the sessions with Patient J. Respondent did not make notes about the sessions, except for two pages of brief notes about Patient J's June 26, 1992 session.

277. Ms. Conroy noted on Patient J's first visit that he was a very emotional child and that he had severe ear infections.

278. Over the next several visits, Ms. Conroy noted that Patient J had temper tantrums, threw things, woke up very early in the morning, and continued to have ear infections. His behavior improved, however, whenever his mother, Patient K, was

feeling better.

279. Although Ms. Conroy's and respondent's notes do not record it, by June 12, 1992, Ms. Conroy had diagnosed Patient J as suffering from major depression. She based this diagnosis on Patient J's family history, loss of appetite, sleep problems, and irritability.

280. At that time, after informally observing Patient J for only a few minutes at a time during, at most, five office visits, and without having performed a direct physical examination of him, respondent prescribed amitriptyline for Patient J because he was not sleeping and was "getting into things" at home.

281. Respondent did not record in her brief notes about Patient J a diagnosis of depression until two weeks after prescribing amitriptyline for him. She was strongly influenced to diagnose Patient J with depression by his demeanor: he was clinging, crying, whining, and had a miserable face. She considered switching the child from amitriptyline to Prozac.

282. "In infants and younger children the common symptoms [of depressive illness] are an excess of normal grief, with inconsolable weeping or wailing for hours on end, or apparent apathy and inertia with failure to respond or to feed." Resp. exh. A183. (Modern Perspectives in Child Psychiatry 486 (J. Howells ed. 1971)).

283. Patient J's behavior was not unusual for a child his age and was not indicative of a major depressive disorder.

284. Patient J's pediatrician, Mark R. Hoffman, M.D., observed that Patient J's behavioral problems seemed to go away when his ear infections were treated, and he was free from pain.

285. Dr. Hoffman also discovered that Patient J's mother, Patient K, did not know why respondent had prescribed amitriptyline for her son and could tell him nothing about the medication other than the fact that respondent had started Patient J on the drug.

286. Amitriptyline is a tricyclic antidepressant. It affects the neurotransmitters in the brain. The 1987-1988 Physicians' Desk Reference carried the following warning for the drug: "Usage in Children--In view of the lack of experience in children, the drug is not recommended at the present time for patients under 12 years of age."

287. In a prefatory note to a 1973 journal article, the editor cautioned: "Although this article has been recommended for publication . . ., the Editor feels it necessary to stress extreme caution (1) in identifying any child as having a

depressive illness and (2) in prescribing any medication for such a disorder. . . . Certainly all children who receive drug therapy on a continuing basis must be carefully monitored for evidences of toxicity and other side effects. The drug used in this study [amitriptyline] has not been approved for use in children less than 12 years of age." Resp. exh. A183. (Weinberg, Rutman, Sullivan, Penick & Dietz, Depression in Children Referred to an Educational Diagnostic Center: Diagnosis and Treatment, 83 Journal of Pediatrics 1065 (1973)).

288. A 1976 journal article submitted by respondent describes the cases of three children successfully treated with amitriptyline for mania or mania and depression. However, these children were all older than Patient J, ranging in ages from almost four to 11. The article also describes the case of a four-year-old girl who experienced a manic episode. Her symptoms were exacerbated by amitriptyline therapy. "Treatment of a subsequent depression with amitriptyline resulted in the reappearance of manic symptoms, which then disappeared after cessation of amitriptyline." Resp. exh. A183. (Weinberg & Brumback, Mania in Childhood, 130 Am. J. Dis. Child 380, 381-382 (1976)).

289. "Antidepressant drugs have been used for school-aged children since 1962 and for preschool children over 18 months of age since 1966. . . . However, there is consensus that when drugs are used, they must be part of a more comprehensive treatment plan that includes a focus on the child's environment, especially family and school. Unfortunately, most of the pharmacological intervention studies have methodological flaws that leave the results inconclusive." Resp. exh. A183. (Kashani, Husain, Shekim, Hodges, Cytryn & McKnew, Current Perspectives on Childhood Depression: An Overview, 138 American Journal of Psychiatry 143, 150 (1981)).

290. "Considering the potential hazards of antidepressant drugs, especially to the cardiovascular system, caution is definitely indicated. . . . In clinical practice, one would be justified in the judicious use of tricyclic antidepressants in children in whom a depressive illness has been reliably diagnosed and who fail to respond to psychotherapy and environmental manipulation. Careful monitoring of side effects and only gradual increments in dosage are definitely indicated. Blood pressure, pulse and EKG should be screened at regular intervals." Resp. exh. A183. (Cytryn & McKnew, Treatment Issues in Childhood Depression, 15 Psychiatric Annals 401, 402-403 (1985)).

291. "[T]he possible cardiotoxicity and reduced seizure thresholds as side effects of tricyclics in children require particular caution in the use of these drugs in pediatric populations. Selection of appropriate dosing regimen and careful monitoring of side effects is essential, as well as proper

preparation of both child and parents for drug treatment." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 894 (1985)).

292. "[T]ricyclic intervention may be most effectively and safely carried out with severely depressed children as inpatients. Inpatient settings permit the consistent monitoring of compliance, vital signs, and plasma levels necessary for such careful treatment." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 897 (1985)).

293. "Until issues of indications for specific [antidepressant] drugs are settled, individual cases must be managed cautiously and systematically. Collection of adequate baseline data, conservative dosing regimens, careful titration to optimal dose, and standardized assessment procedures can be used to evaluate the efficacy of one or more medications with individual cases." Resp. exh. A183. (Simeon & Ferguson, Recent Developments in the Use of Antidepressant and Anxiolytic Medications, 8 Psychiatric Clinics of North America 893, 903-904 (1985)).

294. "[O]f all the psychotropic drugs commonly used in children, the tricyclics call for the greatest caution." Resp. exh. A183. (Office of Technology Assessment, U.S. Congress, Children's Mental Health: Problems and Services 113 (1986) (quoting Conners & Werry)).

295. "The greatest concern with tricyclics is myocardial toxicity." Resp. exh. A183. (Gittelman & Koplewicz, Pharmacotherapy of Childhood Anxiety Disorders, in Anxiety Disorders of Childhood 199 (R. Gittelman ed. 1986)).

296. "The psychology of the developing child . . . poses two problems in psychopharmacologic research. The first has to do with the reliability of psychiatric diagnosis in children. The second has to do with the evaluation of drug response. Often, it is difficult to obtain useful introspective reports from small children. Additionally, rapid developmental changes make it difficult to describe a stable pattern of psychologic malfunction over time. . . . Generally, it is accepted that an evaluation of the psychiatrically disturbed child or adolescent should include an assessment of the family, social, educational, and economic environment. This is both important diagnostically and in making treatment recommendations." Resp. exh. A183. (McDaniel, Pharmacological Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 66 (1986)).

297. "Because psychopharmacologic treatment of children may require lengthy periods of drug administration, it should only be undertaken when absolutely indicated. . . . If the disorder does not respond to nonpharmacologic treatment or if it is sufficiently severe to be dangerous or disruptive to child and family, the physician should not hesitate to initiate a trial of an appropriate drug, always with careful supervision and monitoring of dosage and effects." Resp. exh. A183. (McDaniel, Pharmacological Treatment of Psychiatric and Neurodevelopmental Disorders in Children and Adolescents (Part 1), 25 Clinical Pediatrics 65, 67 (1986)).

298. "[T]ricyclic antidepressants have the potential for adverse and toxic side effects." Resp. exh. A183. (5 Basic Handbook of Child Psychiatry 473 (J. Call, R. Cohen, S. Harrison, I. Berlin & L. Stone eds. 1987)).

299. "The importance of plasma concentrations, rather than dosages [of tricyclic antidepressants], cannot be overemphasized. . . . [I]t is not difficult to recognize the added importance of monitoring tricyclic plasma blood levels in children, who have even more physiologic factors influencing drug handling than do adults." Resp. exh. A183. (P. Trad, Infant and Childlhood Depression 385 (1987)).

300. "In adults, imipramine and the other tricyclics can cause serious adverse effects such as intracardiac conduction problems and impaired memory. Indications are that this class of drug can produce side effects in children similar to those seen in adults. Therefore, blood monitoring and caution are mandated while using tricyclics in prepubescent children." Resp. exh. A183. (P. Trad, Infant and Childlhood Depression 386 (1987)).

301. "Our knowledge of psychotropic drug effects in children and adolescents is still inadequate for a rational and consistent clinical approach. . . . Prior to any drug therapy it is essential that a detailed baseline clinical assessment be undertaken. Assessments during therapy must be frequent, especially during the initial phases. . . . Information obtained from different sources (child, parents, teachers) must be integrated." Resp. exh. A183. (Simeon, Child and Adolescent Psychopharmacology, in Treatment Strategies in Child and Adolescent Psychiatry 134-135 (J. Simeon & H. Ferguson eds. 1990)).

302. As the journal article quoted above shows, studies appearing in 1990 and later, after respondent treated Patient I, continued to emphasize the need for baseline assessment and careful patient monitoring. If anything, respondent should therefore have been more careful in treating Patient J.

303. "Tricyclic antidepressants should not be prescribed

routinely; they should be given when depression persists, with careful clinical and EKG monitoring of the patient, and preferably in inpatient settings." Resp. exh. A183. (Simeon, Child and Adolescent Psychopharmacology, in Treatment Strategies in Child and Adolescent Psychiatry 140 (J. Simeon & H. Ferguson eds. 1990)).

304. Respondent did not provide adequate monitoring and follow-up for Patient J. For a child Patient J's age, respondent should have obtained a baseline EKG, because of the known adverse side effects of tricylic antidepressants on the heart. Depending upon the results of a baseline EKG, periodic follow-up EKG's may be warranted. Respondent failed to obtain even a baseline EKG for Patient J.

305. At one point, respondent took Patient J off amitriptyline and put him on Pamelor (nortriptyline) for a week, without giving any indication in Patient J's medical records why she was changing his medication.

306. Pamelor, like amitriptyline, is a tricyclic antidepressant. The Physicians' Desk Reference contains the following warning for Pamelor: "Use in Children--This drug is not recommended for use in children, since safety and effectiveness in the pediatric age group have not been established."

307. A pilot study in the use of nortriptyline in major depressive disorder in children examined use of the drug in subjects aged five through 11. None of the children in the study was as young as Patient J. The pilot study recommended that further controlled studies be undertaken. Resp. exh. A183. (Geller, Perel, Knitter, Lycaki & Farooki, Nortriptyline in Major Depressive Disorder in Children: Response, Steady-State Plasma Levels, Predictive Kinetics, and Pharmacokinetics, 19 Psychopharmacology Bulletin 62, 63-64 (1983)).

308. Informed consent is a mandatory process by which a physician, before undertaking a treatment plan, informs the patient or the patient's parent or guardian about the nature and character of the diagnosis, the range of potential treatments, the risks and benefits of potential treatments, and the follow-up necessary to implement the treatment plan effectively. The patient, parent, or guardian then has the opportunity to agree or disagree with the treatment plan based upon the information received from the physician.

309. Respondent does not use an informed consent form. She did not document in Patient J's medical records the obtaining of informed consent from Patient J's mother, Patient K.

310. The documenting of informed consent in a patient's medical records is important, because such documentation provides

subsequent caregivers and others important information about the decisions and factors weighed and considered in the prescribing of a particular medication. Documenting informed consent also provides some legal protection for the physician.

311. Respondent's treatment of Patient J was a gross violation of the standard of care. Her management of Patient J's case was deficient and substandard.

312. She failed to adequately evaluate Patient J with the range of tools and protocols expected to be used before arriving at any diagnosis, particularly a diagnosis of a major disorder. Instead, she relied on a few brief, informal observations of Patient J, her own inadequate "student health history" form, and information received from Ms. Conroy, who was unlicensed in any mental health field at the time.

313. She failed to perform a direct physical examination of Patient J in connection with diagnosing and treating him with powerful drugs.

314. She failed to document in Patient J's medical records her reasoning in connection with her diagnosis of depression. She listed some aspects of his behavior (including hyperactivity, aggression, insomnia, and mood swings) but did not explain why such behavior led to her diagnosis. She recorded nothing about other possible diagnoses that could have explained his behavior.

315. She failed to articulate a cogent treatment plan. Her two pages of sketchy notes on Patient J contain no plan at all.

316. She prescribed powerful drugs (amitriptyline and Pamelor) based on an inconclusive foundation of short, informal observations and second-hand information from Ms. Conroy.

317. She failed to provide adequate monitoring and follow-up for a pediatric patient taking tricyclic antidepressants. She obtained no plasma blood levels or EKG's, despite the known cardiovascular side effects of such drugs.

318. She failed to obtain documented informed consent from Patient K, Patient J's mother. Her records for Patient J contain no reference whatsoever to informed consent.

Count IX (Patient K)

319. Patient K, age 24, is the mother of Patient J. She and her son began seeing respondent's associate, Sheila Conroy, on May 11, 1992. Patient K sought therapy from Ms. Conroy for post-partum depression and anxiety.

320. Approximately two weeks later, respondent saw Patient

K for the first time. Respondent had Patient K complete a standard form about her background, the Beck [Depression] Inventory, the Hopkins Symptom Checklist, and the Burns Anxiety Inventory. Respondent indicated on the Yale-Brown Obsessive-Compulsive Scale that Patient K experienced severe interference with social functioning because of obsessive thoughts.

321. The written checklists and forms which respondent administered to Patient K were not adequate substitutes for obtaining additional medical records from other physicians who had evaluated Patient K, obtaining a consultation on this complex case, and developing a differential diagnosis.

322. Respondent evaluated Patient K during a one-hour session and diagnosed her as having anxiety and psychotic depression.

323. Ms. Conroy kept most of the treatment notes and records for Patient K, including notes about medications prescribed. Respondent's treatment notes consisted of five pages of sketchy entries concerning two office visits with Patient K. Respondent did record in her notes that Patient K had overdosed at age 16.

324. Respondent's notes on Patient K mainly recorded the patient's feelings of panic and anxiety and did not include any explanation of how respondent reached her diagnosis or what other potential diagnoses respondent may have considered.

325. In her notes about Patient K, respondent's treatment plan was limited to a list of drugs to try (imipramine, Trilafon).

326. Respondent assessed Patient K on only two occasions, during office visits. Ms. Conroy managed Patient K's case. She took most of the notes about the patient. She recorded the patient's medication dosages, medication changes, symptoms, and side effects from the medications, to the extent they were recorded at all.

327. Although she assessed Patient K only twice, respondent prescribed powerful psychotropic medications for her, based on Ms. Conroy's reports. At one point, respondent had Patient K on five such medications at once: imipramine, Anafranil, perphenazine, Xanax, and clonazepam.

328. Imipramine is a tricyclic antidepressant. Like all psychotropic medications, it has the potential for toxicity. Imipramine may cause serious cardiovascular side effects. Resp. exh. A183. (5 Basic Handbook of Child Psychiatry 461 (J. Call, R. Cohen, S. Harrison, I. Berlin & L. Stone eds. 1987)).

329. Anafranil (clomipramine hydrochloride) is a tricyclic antidepressant. Possible side effects of this drug include seizures. Resp. exh. A183. (Flament, Rapoport, Berg, Sceery, Kilts, Mellstrom & Linnoila, Clomipramine Treatment of Childhood Obsessive-Compulsive Disorder, 42 Archives of General Psychiatry 977, 980 (1985)).

330. Working with Ms. Conroy, respondent often changed or adjusted Patient K's medications. Even when, in Patient's K's view, they got her medication types and dosages "right on the ball," they would increase one medication or decrease another.

331. The medications prescribed by respondent for Patient K were all potent psychotropic drugs that require careful monitoring and evaluation.

332. Patient K had a great deal of difficulty getting in touch with respondent when she experienced side effects from the medications. When Patient K would call respondent's office, respondent would routinely be too busy to talk with her. Patient K would have to describe her symptoms to respondent's secretary or Ms. Conroy. The secretary or Ms. Conroy would then relay to Patient K what respondent was going to do in response to Patient K's call. Respondent was hardly ever available for Patient K.

333. Patient K called respondent's office frequently to complain about experiencing bad reactions to the medications respondent had prescribed. In response, respondent would switch, increase, decrease, add, or delete medications from Patient K's regimen.

334. At one point, Patient K experienced hallucinations from the medications respondent had prescribed for her, took an overdose in a suicide attempt, and had to be hospitalized.

335. After she was discharged from the hospital, Patient K returned to respondent for treatment, because she was addicted to Xanax and because she could not find another physician who would accept Medicaid patients.

336. Respondent continued to prescribe strong psychotropic drugs for Patient K, including Xanax, lithium, and amitriptyline.

337. Despite prescribing these powerful drugs, respondent never performed a physical examination of Patient K. Respondent ordered and obtained only one lithium level for Patient K while prescribing lithium for her. This was inadequate. Blood testing is especially important when lithium is prescribed, because lithium toxicity is closely related to serum lithium levels and can occur at doses close to therapeutic levels.

338. [DELETED]

339. After Patient K discontinued therapy with respondent and Ms. Conroy, Patient K's family physician, Dr. Hoffman, tested Patient K and discovered that she had a mitral valve prolapse that caused her heart to race, and an infection around her heart.

340. "When in doubt about the cardiovascular state of the patient, a complete (noninvasive) cardiac evaluation is indicated before initiating treatment with a TCA [tricyclic antidepressant] to help determine the risk versus benefit ratio of such an intervention." Pet. exh. 62 at 497. (Biederman, Sudden Death in Children Treated with a Tricyclic Antidepressant, 30 Journal of the American Academy of Child and Adolescent Psychiatry 495, 497 (1991)). Respondent failed to do this for Patient K.

341. Respondent did not obtain documented informed consent from Patient K. Her records for Patient K are devoid of any reference to informed consent.

342. Respondent made no documentation of informed consent in her records for Patient K even after the practice had been recommended in a continuing medical education course she attended and at a time when several complaints against her had already been filed with the Board.

343. Respondent's treatment of Patient K was a gross violation of the standard of care. Her management of Patient K's case was deficient and substandard.

344. She failed to adequately evaluate Patient K with the range of tools and protocols expected to be used before arriving at any diagnosis, particularly a diagnosis of a major disorder such as psychotic depression. Instead, she relied on information she gathered during two office visits and information received from Ms. Conroy, who was unlicensed in any mental health field at the time.

345. She failed to perform a complete and thorough evaluation of Patient K in connection with diagnosing and treating her with powerful drugs.

346. She failed to document in Patient K's medical records her reasoning in connection with her diagnosis of psychotic depression and anxiety. She listed some of Patient K's feelings (including guilt, hopelessness, helplessness, and worthlessness) but did not explain why Patient K's feelings led to her diagnosis. She recorded nothing about other possible diagnoses that could have explained Patient K's symptoms.

347. She failed to articulate a cogent treatment plan. Her five pages of sketchy notes on Patient K contain no plan at all.

348. She prescribed powerful psychotropic drugs based on an

inconclusive foundation of two office visits and second-hand information from Ms. Conroy.

349. She failed to provide adequate monitoring and follow-up for a patient taking, among other drugs, tricyclic antidepressants, lithium, and benzodiazepines. She obtained only one lithium blood level, despite the necessity of closely monitoring serum lithium levels, especially when initiating therapy.

350. She failed to obtain documented informed consent from Patient K. Her records for Patient K contain no reference whatsoever to informed consent.

Count X (Patient L)

351. Patient L is [redacted] She wished to have her name made public at the hearings. She first met respondent in March 1990 when she sought help for her children, who were having problems because their parents were going through a difficult separation.

352. Some time after her children began seeing respondent, [redacted] began therapy with respondent for her own problems centering around her separation and divorce.

353. [redacted] discontinued therapy with respondent after an incident at respondent's office in July 1992. Threatening to kill herself, [redacted] brought a gun to respondent's office. [redacted] had a stand-off with the police, eventually surrendered, and was arrested.

354. Before consulting respondent, [redacted] had a complicated physical and psychiatric history. She had been diagnosed with cardiac problems, an unusual blood disorder, a factitious illness disorder (Munchausen Syndrome), and a history of alcoholism. Respondent was familiar with this medical history and with [redacted] cardiac and alcohol problems.

355. [redacted] cardiac problem was tachycardia, a racing heartbeat. Respondent believed that this was due to [redacted] anxiety and was not a serious problem. However, another physician had viewed [redacted] as a possible candidate for a pacemaker. [redacted] had been prescribed nitroglycerine for her rapid heartbeat. [redacted] did have a heart problem at the time respondent was treating her.

356. [redacted] understanding of the treatment plan was that respondent would help her get through her divorce and her accompanying depression. Almost immediately after [redacted] commenced therapy with her, respondent gave [redacted] sample packets of Prozac from her office supply. Respondent began

writing prescriptions for [redacted] approximately a month after [redacted] began treatment with her.

357. The medications that respondent prescribed for [redacted] included amitriptyline, Klonopin, diazepam, lorazepam, and Anafranil. Respondent treated [redacted] for alcoholism by prescribing Antabuse for her. Antabuse is a treatment for alcoholism which presents very high risks when taken with alcohol. Despite [redacted] problems with alcohol, respondent also prescribed three different benzodiazepines simultaneously for her (clonazepam, lorazepam, and diazepam).

358. If benzodiazepines are prescribed for anyone with an alcohol problem, they must be used with care. Two basic causes for concern in giving benzodiazepines to patients with alcohol problems are that they may become addicted to them and that they may abuse them by taking overdoses.

359. Respondent did not discuss with [redacted] the effects of alcohol in combination with the benzodiazepines. When [redacted] questioned a medication or mentioned concerns she had about certain side effects she was experiencing, respondent got upset and accused [redacted] of questioning her authority.

360. Despite [redacted] cardiac history, respondent prescribed amitriptyline for her. Respondent never discussed the effect amitriptyline might have on [redacted] heart condition or the danger of taking an overdose of amitriptyline.

361. Shortly after respondent first prescribed amitriptyline for her, [redacted] took too much of the drug, blacked out while driving, and hit an embankment with her car. After the accident, [redacted] was admitted to the Rutland Regional Medical Center. [redacted] spent three days in the hospital being detoxified from her amitriptyline overdose. The level of amitriptyline in her system was over twice the amount considered toxic.

362. Two days before her car accident, [redacted] had complained to respondent that she was confusing appointment days and making mistakes at bingo. Respondent noted that [redacted] confusion and memory loss may have been caused by the medication respondent was prescribing.

363. After [redacted] car accident, respondent continued to prescribe amitriptyline for her, despite the fact that the cause of [redacted] car accident was an amitriptyline overdose.

364. Tricyclic antidepressants such as amitriptyline are potentially lethal in overdose. Possible adverse reactions include heart attack and stroke. Nevertheless, respondent was not concerned about prescribing amitriptyline for [redacted], a

patient with a history of heart problems.

365. [redacted] experienced other side effects from the medications prescribed by respondent, including lightheadness, dizziness, dry mouth, shortness of breath, suicidal thinking, and inability to sleep. She was lethargic and tired much of the time and slurred her speech. Her memory loss caused her to lose track of days at a time.

366. [redacted] will no longer take the types of psychotropic medications prescribed by respondent, because of the side effects she experienced from them. Since [redacted] stopped seeing respondent as her psychiatrist, she has not had suicidal thoughts, has not been in jail, has not been in any car accidents, and has not suffered any memory losses.

367. Respondent's prescription practices regarding [redacted] fell below the standard of care on repeated occasions. The medications prescribed were inappropriate. As many as four or five medications were prescribed at one time, and many different medications were prescribed over a period of two and one-half years.

368. Respondent's continued prescribing of amitriptyline for [redacted], after she had taken an extremely toxic dose resulting in a car accident, was inappropriate and fell below the standard of care. Respondent should have been concerned about prescribing amitriptyline for [redacted] because of her cardiac history and her toxic overdose.

369. Respondent further violated the standard of care by prescribing three different benzodiazepines simultaneously in a patient who presented with a history of alcohol problems and factitious illness.

370. Respondent attempted to justify the use of multiple and changing medications for [redacted] by saying that [redacted] had a "constantly changing anxiety picture." However, respondent also admitted that there was always a question with any medications prescribed for [redacted] that she might harm herself.

371. Respondent's record keeping with respect to [redacted] prescription medications also fell below the standard of care. A review of the records revealed that they were so sub-standard that it was difficult to determine what medications respondent was prescribing for [redacted]. The records also indicated that the medications and their dosages were changed frequently without proper documentation or evaluation.

372. Respondent's conduct also fell below the standard of care with respect to [redacted] because she failed to properly communicate with [redacted] about the direction, purpose, risks,

and benefits of the treatment plan. This failure was particularly egregious, given the fact that, at times, respondent saw [redacted] five times a week for individual psychotherapy and prescribed from every category of psychotropic medications: anti-anxiety, anti-depressant, anti-psychotic and anti-obsessional.

373. Respondent also violated the standard of care by not seeking a consultation with another physician about this complicated patient and by failing to refer her to someone with more expertise. Respondent did not have sufficient advanced training needed to undertake the psychiatric care of as complicated a patient as [redacted].

374. Respondent's use and management of pharmaceuticals with [redacted], especially the use of benzodiazepines over a protracted length of time in a patient with alcohol problems, repeatedly fell below the standard of care that a reasonable, prudent physician would have practiced.

Count XI (Patient L)

375. On a Friday afternoon in September 1991, [redacted] arrived for her appointment with respondent. After waiting for some time in respondent's waiting room, [redacted] became concerned and progressively more anxious about her 14-year-old daughter at home.

376. [redacted] began to experience chest pain and tachycardia, which frightened her.

377. When she finally saw respondent for her therapy appointment, [redacted] described her rapid heartbeat to respondent. Respondent believed that the rapid heartbeat was due to anxiety and gave [redacted] Xanax, a benzodiazepine and an anti-anxiety medication, to slow her heart rate. When that did not help the fast heartbeat, respondent gave [redacted] more Xanax or Valium.

378. Within fifteen minutes of taking the pills, [redacted] head began to hurt, and the room began to spin. Respondent made up a bed for [redacted] on a pull-out couch in another room in the office.

379. [redacted] had not planned on spending the night at respondent's office. She again became concerned for her daughter, who was at home waiting for her.

380. Respondent did not send [redacted] home that night because it was late, and she judged that [redacted] 14-year-old daughter might not be able to control [redacted]. [redacted] was not in any condition to drive, because the medication respondent had given her made her sleepy and unsteady.

381. Respondent called [redacted] daughter, and told her that her mother would not be coming home that evening because she was having heart trouble and would, therefore, be staying at respondent's office. Respondent told [redacted] to go next door to her father's house and stay there for the weekend.

382. [redacted] spent the night sleeping on the pull-out bed in respondent's office.

383. Witness S had been a patient of respondent's and subsequently did some computer work for respondent on the weekends. Witness S and respondent were also friends. On the Saturday morning after [redacted] had spent the night at respondent's office, respondent telephoned Witness S and asked if she was coming into the office. Respondent then told Witness S that [redacted] was sleeping upstairs in the office and asked Witness S to check on her and make sure she took her medication.

384. Witness S had no medical training or expertise.

385. Witness S arrived at respondent's office. At some point during the day, Witness S got [redacted] a glass of water and made sure that [redacted] took more medication. Witness S also offered [redacted] something to eat, but [redacted] declined because she was so tired from the medication. [redacted] fell asleep for the entire day and next night in respondent's office, waking occasionally and talking to Witness S.

386. Respondent called her office at least once during this time to inquire about [redacted] status. Witness S did not know where respondent was or how she could be reached in case of an emergency.

387. On Sunday morning, respondent came into the room where [redacted] was sleeping and told [redacted] that she had contacted [redacted] sister to drive Ms. Rowe home. [redacted] was still unable to drive because of the effects of the medication.

388. [redacted] was taken to her home by her sister. [redacted] was still experiencing extreme tiredness. It took [redacted] several days of bedrest to recover from the medications respondent had instructed her to take that weekend.

389. Respondent grossly deviated from the standard of care by lodging [redacted] at her office for the weekend, after [redacted] complained about chest pain. Respondent did a cursory evaluation, failed to order an EKG or further testing, and did not refer [redacted] to someone with more expertise. Respondent simply gave her some medication and told her to lie down.

390. [redacted] was in an unconscious state for an extended

period of time. During this time, respondent entrusted her care to another person who had no medical training. This was inappropriate and was also a breach of [redacted] confidentiality. It was dangerous for [redacted], and it put Witness S in a very difficult situation. The episode was very disorienting and confusing for [redacted].

391. During the time that respondent was treating [redacted], Sheila Conroy facilitated having another patient, Patient M, move into [redacted] home with respondent's knowledge. Respondent had mentioned to Ms. Conroy that [redacted] was looking for a female roommate to help with finances and to provide companionship.

392. [redacted] discussed the planned arrangement with respondent before Patient M moved in with her.

393. [redacted] did not know anything about Patient M's ex-husband before Patient M moved in with her. Sheila Conroy facilitated the move even though she knew that there was a pending court case alleging that Patient M's ex-husband had molested their young daughter.

394. When [redacted] eventually learned about Patient M's ex-husband, including the fact that he was abusive to Patient M, [redacted] confronted respondent and asked why she had not been told of this history. Respondent cited patient confidentiality.

395. [redacted] was very angry when she learned the details about the ex-husband and insisted that Patient M get a restraining order.

396. During the time that she lived with [redacted], Patient M had a boyfriend. Patient M's boyfriend had a drinking problem and brought alcohol to [redacted] house when he visited. When he brought alcohol to the home, [redacted] would get drunk with him.

397. One night, Patient M returned from work to find that [redacted] had passed out because she had drunk alcohol and taken some sleeping pills. Patient M and [redacted] daughter had trouble waking [redacted], so they called respondent's office and spoke with Ms. Conroy. Patient M was told to bring [redacted] to the office the next day.

398. After living with [redacted] for a few months, Patient M moved out when [redacted] accused her of stealing some money.

399. The living arrangement that Sheila Conroy facilitated, with respondent's knowledge, between [redacted] and Patient M, adversely affected both Patient M's and [redacted] lives, in that it created severe stress. Having Patient M move in with [redacted] also adversely affected [redacted] daughter, because she was afraid of Patient M's ex-husband.

400. Respondent grossly violated the standard of care by agreeing to the living arrangement between Patient M and [redacted]. The arrangement was a totally inappropriate match, which led to many problems for both patients.

Count XII (Patient L)

401. At one point during her treatment with respondent, [redacted] was scheduled to appear in Rutland Family Court regarding contested issues of child support. During one of [redacted] regular appointments, respondent told [redacted] that she would accompany her to the court proceeding. Respondent had been to at least two other hearings with [redacted].

402. On the day of the court hearing, [redacted] waited outside the courthouse for respondent to arrive. Instead, Patient N came in respondent's place and informed [redacted] that respondent would not be able to attend the court hearing because she was ill. [redacted] felt uncomfortable that Patient N was there in respondent's place. It soon became apparent to [redacted] that Patient N knew certain things about her that [redacted] had told only to respondent.

403. Respondent had instructed Patient N to give [redacted] some prescription medication (Xanax) before she went in to the court hearing. [redacted] told Patient N that she did not want to take the medication. After Patient N reminded her that they both knew respondent's temper when they disobeyed her orders, [redacted] took the medication.

404. During the hearing, [redacted] was unable to concentrate, became confused, and attempted to leave at one point. As a result of [redacted] behavior, the hearing had to be rescheduled for another day.

405. A few days later, during a scheduled appointment, [redacted] confronted respondent about the breaches of confidentiality and about the failure of respondent to attend the court hearing. Respondent told [redacted] that she had not gone to the court proceeding with her because she was not going to let [redacted] "make a goddamn fool" out of her.

406. In response, [redacted] told respondent that if respondent ever did anything like that again, [redacted] would report her to the Board of Medical Practice and would file a lawsuit. Respondent then slapped [redacted] across the face.

407. On another occasion, [redacted] daughter, [redacted], who was seeing Sheila Conroy in therapy, was told by respondent and Ms. Conroy not to discuss with [redacted] the fact that respondent and Ms. Conroy had spoken to her father, [redacted] ex-husband.

408. [redacted] had not given Ms. Conroy or respondent permission to speak with her father about personal confidences shared in therapy. Because she did not want to keep any secrets from her mother, [redacted] told her mother that respondent and Ms. Conroy had spoken with her father. [redacted] became extremely upset, and both she and [redacted] went immediately to respondent's office to confront her about this breach of confidentiality.

409. When [redacted] confronted respondent at her office, respondent got very angry, swore at [redacted], and shook her very forcefully. This made [redacted] upset and frightened her daughter.

410. Both [redacted] and her daughter felt betrayed by respondent's breach of confidentiality.

411. [redacted] assessment of respondent's treatment of her was, "I came out worse than when I went there." She now tape-records all sessions with physicians, because she does not trust them as a result of her experience with respondent.

412. By hitting, shaking, swearing at, and humiliating [redacted], respondent grossly violated the standard of care of a reasonable, prudent physician.

413. Respondent grossly violated the standard of care by her breach of [redacted] confidentiality in informing Patient N about certain of [redacted] confidences.

414. Respondent also grossly violated the standard of care by instructing Patient N to give [redacted] medication.

Count XIII (Patient O)

415. Patient O, a man who is now 40 years old, grew up in New Jersey. His case was difficult and complex.

416. Patient O started using illicit drugs, including heroin, when he was 14 years old. He used opiates continuously until he was 28 years old, although he made several attempts at methadone maintenance during that time. At one point during this period, he was spending as much as $200 a day on heroin.

417. When he was 28 years old, Patient O came to Vermont and, on his own, detoxified himself. Approximately half a year after arriving in Vermont, he started counseling at Rutland Mental Health Services because he was suffering from depression. He sporadically attended counseling sessions for several years.

418. In 1987, while working on a carpentry job, Patient O fell at a construction site and injured his back. After his

accident, he underwent physical therapy for three or four months. He was also given codeine for two months for the pain he was suffering. Patient O had been free of drugs since arriving in Vermont four or five years earlier. However, the codeine triggered another bout with opiates. After a period of time, he began to use the pain to justify using opiates.

419. Patient O visited different physicians to obtain prescriptions for opiates. Soon, he began to use illegally-obtained heroin.

420. In 1989, after he and his wife realized that his addiction had gotten out of control, Patient O started treatment with respondent.

421. At the time he first went to respondent, Patient O had been injecting liquid opium, which he was getting from doctors in Burlington. He had been using his back condition as a reason to get drugs from those doctors, even though his back pain at that time was minimal.

422. Patient O's wife, Witness P, accompanied him on his first visit to respondent's office. That visit lasted about an hour. His wife accompanied him for support and to make sure he was honest about his addiction problems. Most of the first session was spent talking about his addiction.

423. To illustrate the extent of his addiction problems, Patient O pulled down his pants to show respondent the needle marks on his buttocks. This was the full extent of any physical examination of Patient O that respondent performed.

424. Patient O filled out a form at the first visit. Under "Presenting Problem(s)," he listed: "Depression, depression, low self esteem, drug addiction out of control."

425. Patient O and respondent focussed on discussing his addiction during that session and spent a much shorter amount of time discussing Patient O's depression.

426. During that session, Patient O explained to respondent how his addiction had flared up again because of the accident in which he hurt his back. However, neither at that session, nor at any other time, did respondent examine his back.

427. Patient O and respondent also discussed her prescribing methadone to help with his addiction. Patient O's wife asked about treatment in a drug rehabilitation center, but respondent indicated that she could handle the treatment and that she would have him detoxified and stabilized in approximately three months. Patient O left respondent's office with a methadone prescription she had written and some sample packets of

Prozac for his depression.

428. A physician wishing to use methadone for the purpose of maintenance or detoxification treatment of drug addiction must obtain a special federal license and must follow prescribed standards. Respondent did not obtain such a license and violated the federal standards for methadone maintenance or detoxification treatment of narcotics addicts.

429. Respondent did not perform the minimum medical evaluation of Patient O, as required by 21 C.F.R. § 291.505(d)(3)(i).

430. Before treating Patient O with methadone, respondent did not have Patient O interviewed by a well-trained drug treatment program counselor to determine the appropriate treatment plan for Patient O, as required by 21 C.F.R. § 291.505(d)(3)(iii).

431. Respondent started Patient O on 60 milligrams of methadone a day, thereby failing to ensure that the total dose for the first day did not exceed 40 milligrams, as required by 21 C.F.R. § 291.505(d)(6)(i)(A).

432. Respondent did not observe Patient O on a daily basis or six days a week during the course of his methadone treatment, did not follow the criteria for reducing that frequency, and did not limit the take-home methadone to a two-day supply, as required by 21 C.F.R. § 291.505(d)(6)(v)(A)(1). Her failure to abide by the take-home requirements was not excused by any exceptions, because none of the exceptions from the take-home requirements listed in § 291.505(d)(6)(vi) was applicable.

433. Patient O could not find a pharmacy to fill the methadone prescription, so he returned to respondent's office. Respondent wrote a prescription for him for morphine sulfate. Using prescriptions written by respondent, Patient O received morphine sulfate for two weeks.

434. Patient O and his wife returned to respondent's office a week after the first visit. At the end of the second visit, Patient O used a telephone at respondent's office to call a number of pharmacies to try to locate one that had a supply of methadone. Ultimately, he located a pharmacy in another town that had some methadone on hand. He got respondent's prescription filled there.

435. Thereafter, Patient O had weekly appointments with respondent. During each session, respondent would write prescriptions for methadone and Prozac sufficient to last until Patient O's next appointment. In this way, Patient O continued to receive methadone prescriptions from respondent for

approximately two years.

436. At one point, Patient O presented a methadone prescription at a pharmacy in Rutland. Because the pharmacist on duty, John Dorvee, knew Patient O to be an opiate abuser, he telephoned respondent about the prescription and advised respondent that Patient O was an opiate abuser. Respondent told Mr. Dorvee that she knew that Patient O was an opiate abuser and that she was trying to wean him off opiates. Respondent never mentioned pain as a reason for prescribing methadone for Patient O during the phone conversation. Mr. Dorvee refused to fill the prescription, because he knew that respondent's intent to prescribe methadone to detoxify Patient O was in violation of federal law.

437. During his visits to respondent, Patient O sometimes mentioned that he was suffering from some back pain and muscle spasms. At one point, respondent prescribed clonazepam for his spasms and his anxiety. She also gave him other benzodiazapines for the muscle spasms.

438. When he first started seeing respondent, Patient O would occasionally tell her that he had dreams about craving illicit drugs. Her response to his confiding this to her was to get upset with him, yell at him, and swear at him. Patient O felt demeaned by respondent and, to avoid her anger, he learned not to tell her when he had feelings about wanting drugs.

439. Once, when respondent discovered that Patient O had gone back to using heroin, she abruptly cut him off from all of his medications and would not give him any more prescriptions. Patient O became frantic, because he could not tolerate being cut off from the medications. He suffered from nausea and diarrhea and became extremely irritable. He sought relief in street drugs.

440. Patient O eventually realized that if he did what respondent wanted, he could get more pills. If he did something wrong, she would shut him off and not give him any medication. In this way, respondent used her drug prescribing powers to manipulate Patient O.

441. Respondent yelled and screamed at Patient O on several occasions. On one occasion, Patient O heard respondent screaming at another patient. Respondent was yelling so loudly at the other patient that Patient O could hear her one floor down and through closed doors.

442. On one occasion, Patient O's wife saw respondent become furious and yell at Patient O. She also heard respondent call the father of a young patient an "asshole" when the father told respondent he did not want to put his son on any drugs.

443. Patient O's wife became concerned about the treatment respondent was rendering to Patient O. Her concern arose when she learned that respondent had lost her privileges at the local hospital. She also became concerned because Patient O's depression persisted and because respondent was continuing to provide him with methadone past the time that she had originally indicated that he would be detoxified. Patient O's wife called respondent's office, but her calls went unanswered. Finally, she went to respondent's office, where respondent reiterated that she was treating Patient O appropriately.

444. Patient O's wife also became concerned that respondent had prescribed Dilaudid for Patient O, because he had a history of abusing that drug. Again, she repeatedly tried calling respondent, but respondent did not return her calls. Finally, she called respondent's office and said that she had to talk to respondent because it was a matter of life and death. At that point, respondent spoke with her and told her that Patient O was her patient and she would deal with him as she saw fit. Patient O's wife was so frustrated and alarmed by respondent's reaction that she called the Board of Medical Practice.

445. After approximately two years of treatment with respondent, Patient O entered treatment for his drug dependence at a clinic in Massachusetts. This treatment lasted for approximately four to six weeks. As part of that treatment, Patient O received methadone. Because federal law requires it, he had to go to the clinic every day to receive his methadone.

446. Patient O ceased treatment at the clinic because he returned for treatment with respondent. His reason for returning to respondent was that he wanted to avoid having to make daily trips to Massachusetts for his methadone. During the second session after Patient O returned to treatment with her, respondent again started writing methadone prescriptions for him. Under those prescriptions, Patient O received methadone in pill form. When methadone is received in pill form rather than in the liquid form dispensed in a federally regulated methadone maintenance or detoxification clinic, it is much easier for the recipient of the methadone to hoard the drug and then sell it on the street.

447. As before, Patient O would visit respondent's office only once a week. At no time during his first two sessions after returning to respondent did Patient O in any way discuss his back pain with her. Back pain was not a focus of the treatment he was receiving. Instead, respondent and Patient O concentrated on his addiction and depression.

448. Patient O received methadone from respondent for treatment of his addiction problem, not for treatment of pain.

449. At one point, while Patient O was respondent's patient, he arranged for a couple he knew to see respondent for treatment. The couple abused opiates. Patient O accompanied the couple on their first visit to respondent's office and acted as an advisor to respondent on the kind of treatment the couple would receive.

450. Respondent made out the first prescription for the couple in the name of Patient O. At her direction, he took it to a pharmacy, had it filled, and returned the drug to respondent. Respondent then dispensed the drug to the couple.

451. Respondent wrote the next two prescriptions for the wife even though she knew that the husband would also be taking the drugs. Respondent did this because she was already under scrutiny by the Board. Since the wife was the member of the couple with the most physical problems, respondent felt that the prescription would appear to be more legitimate if written ostensibly for the wife's pain.

452. During the time he was in therapy with her, and even during therapy sessions, Patient O had discussions with respondent about the two of them going into business together to run a methadone clinic. As part of the process of looking into this business endeavor, Patient O contacted federal agencies to obtain the proper paperwork to run a clinic. He also attended a meeting to discuss this issue with respondent and the director of the Vermont Division of Alcohol and Drug Abuse. Respondent and Patient O traveled together to this meeting in St. Johnsbury.

453. In August 1992, while under respondent's treatment, Patient O had a serious automobile accident. He broke his right leg in four places and lost one of his kneecaps. Patient O sought treatment for his injuries at the Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire. That facility did not give him methadone but, instead, prescribed Elavil for his depression and Percocet for his pain, even though his pain was greater than it had been before the accident.

454. At Dartmouth-Hitchcock, Patient O was offered and entered into a written treatment contract because he was receiving opiates. At no point did Patient O ever enter into such a contract with respondent.

455. By the summer of 1993, respondent had become concerned that there was an attempt by the medical community to have her removed from practice. Respondent perceived a certain Dr. Thomas, a physician in the Rutland area, as a threat. In an attempt to protect herself, respondent gave Patient O a small tape recorder and told him to make an appointment with this physician. Patient O was instructed by respondent to try to record Dr. Thomas setting forth his concerns about respondent.

Respondent wanted some evidence that the physician was out to get her. Patient O did as respondent had requested and then returned to her office, where they played the tape together.

456. In late 1993, Patient O got himself admitted to the Brattleboro Retreat. During the intake process at the Retreat, Patient spoke negatively about respondent's treatment of him. After a brief stay at the Retreat, Patient O returned to treatment with respondent.

457. Respondent learned of Patient O's negative comments at the Retreat because they had been included in the Retreat's intake summary. She asked Patient O to write to the Retreat to try to change his statements. Patient O drafted a letter to the Brattleboro Retreat and, at a therapy session, allowed respondent to review it. Respondent was not happy with the letter, so for that session, Patient O sat in respondent's office while she wrote down what she wanted Patient O to type and give to the Retreat.

458. When Patient O took the revised letter home to re-type it according to respondent's instructions, he could not bring himself to re-type and mail the letter. He felt that respondent was manipulating him.

459. Turning back to discussion of an earlier period of Patient O's treatment with respondent, Patient O eventually reached a point after approximately a year of treatment where he felt he could discuss some extremely personal and sensitive issues with respondent. As a child, Patient O had been sexually abused. Since his youth, he had, on occasion, dressed in women's clothes. Because of his trust in respondent, Patient O felt that he could discuss these issues with her.

460. Respondent's reaction to hearing about Patient O's cross-dressing was to listen and comfort him. After much talking about the issue, respondent and Patient O decided that he should come to her office in women's clothing so that they could do some role-playing.

461. Respondent and Patient O even discussed his getting dressed up in women's clothes and their going out together in public that way. Respondent explained to Patient O that this would give her a better understanding of what he was going through.

462. On one occasion, Patient O got dressed in women's clothes, expecting to meet respondent at the Holiday Inn in Rutland. However, respondent was running late with her patient appointments, so Patient O went to her office instead. He arrived there at approximately 9:30 p.m.

463. Patient O had taken methadone and Valium that evening. Respondent had suggested that he medicate himself to lessen his anxiety.

464. Respondent and Patient O sat in the office reception area for a little while, and then Sheila Conroy joined them. Respondent and Ms. Conroy complimented Patient O on how he looked dressed as a woman.

465. Respondent and Patient O later went upstairs to a living room area in respondent's office. They talked about how Patient O looked and how his appearing in women's clothes could be a useful tool in his therapy.

466. After a time, respondent began touching Patient O softly and sensuously on his knees and thighs. She spoke quietly to him, telling him to let himself go. Patient O detached himself mentally from what was happening. He sensed that something was not right. This episode lasted approximately half an hour. Patient O felt demeaned by this episode.

467. Patient O's wife had helped him to get dressed and made up before he went to respondent's office cross-dressed, thinking that this would be a good way for him to deal with his problem. When Patient O returned home from respondent's office, he was dejected and, according to his wife, "destroyed". His wife has never seen him so crushed either before or after that evening.

468. Patient O was afraid to discuss the episode with respondent, because he feared she would get angry with him and withhold his medication.

469. With respect to the this incident, respondent grossly violated the standard of care. Conduct by a physician that exploits a patient and greatly disturbs him is not acceptable under any circumstances.

470. Respondent's consulting with Patient O about prescribing medications for two patients was a gross violation of the standard of care. A physician should not consult with one patient about another patient's medications. Such a consultation violates patient confidentiality, is an abdication of the physician's responsibility, and puts an unfair burden on the patient acting as the "consultant."

471. Respondent prescribed methadone for Patient O for other than legal and legitimate therapeutic purposes. She prescribed methadone for his narcotics addiction, not for his pain. She did not possess the federal license necessary to treat narcotics addicts by prescription, on an outpatient basis.

472. Respondent willfully omitted to file or record medical reports required by law. She failed to file any reports with the Vermont Department of Health regarding her treatment of Patient O for his narcotics addiction. A physician is required by law to file a report with the Department of Health whenever the physician treats a patient for the use of, or for problems arising from the use of, regulated drugs such as narcotics.

473. Respondent's prescribing methadone for Patient O was a gross violation of the standard of care. Any physician wishing to use methadone for maintenance or detoxification treatment of drug addiction must first obtain a federal license to do so. Respondent never obtained such a license. She failed to abide by all of the requirements that accompany such a license. The ordinary, reasonable physician who is treating an addict with methadone will follow those requirements. Following the requirements is necessary, because the requirements provide important standards for medical evaluations, drug screening, the dispensing of take-home medication, and recordkeeping. When a physician operates outside of the guidelines, patient harm, such as overdosing, can result.

474. Respondent also grossly violated the standard of care by screaming and yelling at Patient O, using loud, heated, and profane language with him, and manipulating him by redrafting his letter to the Brattleboro Retreat and by cutting him off from his medications when she did not like his conduct.

Count XIV

475. Count XIV is an aggregation device that apparently asks the factfinders to go back to each previous count, determine that simple failure to uphold the standard of care occurred in those counts, and then consider all of those simple failures together as "repeated" failure for purposes of the 26 V.S.A. § 1354(22).

476. The language of § 1354(22) is couched in the alternative; the factfinders may determine that allegations proved constitute either gross or repeated simple failure to uphold the standard of care. One isolated instance of simple failure does not constitute unprofessional conduct.

477. The hearing committee has already found repeated violations of the standard of care in each of Counts I through V and in Count X. To use Count XIV to again find repeated violations under Counts I through V and Count X would be superfluous.

478. In Counts VII through IX and Counts XI through XIII, "gross" failure and "repeated" failure to uphold the standard of care were charged in the alternative.

479. The hearing committee has already found gross violations of the standard of care in each of Counts VII through IX and Counts XI through XIII. To use Count XIV to re-visit Counts VII through IX and Counts XI through XIII to determine that simple failure to uphold the standard of care occurred in each count, so that those simple failures can then be aggregated under Count XIV to find another violation, would not only be superfluous but would also contradict the logic of the hearing committee in originally finding that the allegations in Counts VII through IX and Counts XI through XIII constituted gross failure and not simple, repeated failure.

480. For the foregoing reasons, Count XIV is unnecessary and should be dismissed.

General Findings II

481. Respondent is dangerous to the public. She had a dream of "setting Rutland on fire", metaphorically, with her comprehensive psychiatric rehabilitation practice methodology. To accomplish her ends, she presented herself as a very powerful person. She caused her patients to be afraid of her and in awe of her, and to feel powerless before her and dependent upon her.

482. "Certain patients, such as those with passive-dependent traits or those who have been abused, are particularly vulnerable [to power-seeking and controlling behavior by the therapist]. The willingness of patients to be controlled may tempt therapists to deny the significance of their own behavior." Resp. exh. A28 at 461. (Epstein and Simon, The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy, 54 Bulletin of the Meninger Clinic 450, 461 (1990)).

483. For example, Patient C testified about feeling controlled and helpless while under respondent's care. Patient C and others submitted to respondent's will because they believed that, as the physician, she must have known what was best for them. Yet respondent failed to see the part her own controlling behavior played in their resignation and helplessness.

484. "The severely mentally ill, among the most challenging psychiatric patients, require treatment services of the highest caliber. Psychiatric care must start with accurate diagnosis and development of a carefully designed treatment plan for each patient. Pharmacological therapies must be employed with care and precision in order to provide maximal benefit with minimal unwanted acute or long-term side effects. Optimal symptom control is vital for effective rehabilitation." Resp. exh. A185. (Breakey, Networks of Services for the Seriously Mentally Ill in the Community, in Psychiatry Takes to the Streets 21 (N. Cohen, ed. 1990)).

485. Lack of accurate diagnoses, failure to develop carefully designed treatment plans, failure to employ drug therapies carefully and precisely, and failure to control symptoms optimally characterized respondent's treatment of Patients I, J, K, and [redacted].

486. "It is seldom possible to start from scratch and develop a service network where none existed before. More often such networks grow and evolve. . . . To enable such a growth process to occur, two elements are needed, funding and a coalition of interested parties." Resp. exh. A185. (Breakey, Networks of Services for the Seriously Mentally Ill in the Community, in Psychiatry Takes to the Streets 34 (N. Cohen, ed. 1990)).

487. At all times relevant to this case, respondent had neither the funding nor the coalition of interested parties needed to establish and sustain a service network for her seriously mentally ill patients. Only recently, with the establishment of the Vermont Center for Psychiatric Rehabilitation, has she begun to lay a foundation for obtaining funding and services.

488. "Given . . . the fact that case-management relationships are often as intense and enduring as therapy relationships, case managers have need of close [clinical] supervision in which they can explore and come to understand their reactions to patients." Resp. exh. A185. (Harris, Redesigning Case-Management Services for Work with Character-Disordered Young Adult Patients, in Psychiatry Takes to the Streets 173 (N. Cohen ed. 1990)).

489. Respondent tried to function not only as therapist but also as case manager for her patients. In neither role did she have any clinical supervision. As a result, she was unable to explore or understand her reactions to patients. She frequently became angry with them and still remains angry. For example, at the hearings in this case, she called Patient O, "the biggest liar of all of them," meaning her patients.

490. "Although it may be appropriate in certain clinical situations to address a patient by first name . . ., permitting or encouraging a first-name basis between therapist and patient is a form of false advertising in which a professional relationship designed to offer treatment is misrepresented as a social friendship." Resp. exh. A28 at 457-458. (Epstein and Simon, The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy, 54 Bulletin of the Menninger Clinic 450, 457-458 (1990)).

491. "[T]he use of first names between the psychiatrist and patient . . . may imply a pseudointimacy that can be used by both

parties to avoid dealing with the patient's reasons for being in treatment." Resp. exh. A27 at 425. (13 Review of Psychiatry 425 (J. Oldham & M. Riba, eds. 199-)).

492. Patients repeatedly referred to respondent as "Annette" during the hearings, which indicated that they were accustomed to addressing her by her first name. This fact, together with much other evidence of boundary violations indicates that respondent's psychiatric treatment was intertwined with social friendship behavior (for example, Patient E's home visit and lawn mowing, Patient C's functioning as a social worker/colleague, Patient B's functioning as a personal errand-runner).

493. Obtaining personal gratification by helping to develop a patient's "great potential for fame or unusual achievement" is another way in which a therapist may exploit a patient. Resp. exh. A28 at 460. (Epstein and Simon, The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy, 54 Bulletin of the Menninger Clinic 450, 460 (1990)).

494. As an example from this case, respondent encouraged Patient C to think of herself as a social worker, to be part of a team that would ignite the community.

495. "As a way of validating their own self-worth, mental health professionals are vulnerable to the occupational hazard of becoming entwined in attempts to 'cure' their patients. The 'rescue fantasy' and the high social value placed on helping others can serve as a tenacious defense against recognizing this form of using patients." Resp. exh. A28 at 462. (Epstein and Simon, The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy, 54 Bulletin of the Menninger Clinic 450, 462 (1990)).

496. Respondent succumbed to this form of exploitation of her patients. She prides herself on having inherited an ethic of service to those less fortunate. She believed that she alone could provide all the help needed to cure Patient O of a serious, long-term narcotics addiction.

497. "[A]ngry and confrontational [tones of voice] are likely to have serious ramifications for a patient and may disrupt the therapeutic process. Similarly, verbal abuse under the guise of constructive and therapeutic confrontation exploits the patient and is disrespectful." Resp. exh. A27 at 427. (13 Review of Psychiatry 427 (J. Oldham & M. Riba, eds. 199-)).

498. Here, respondent shouted and swore at patients and others, in her office and elsewhere. She used her temper to control her patients. They feared her and were afraid to go against her wishes or to confront her. Her conduct was not

therapeutic but, rather, was destructive of her relationship with her patients.

499. "Confidentiality is a fundamental and long-standing principle of medical ethics and represents an essential boundary or ground rule in psychotherapy." Resp. exh. A27 at 430. (13 Review of Psychiatry 430 (J. Oldham & M. Riba, eds. 199-)).

500. In this case, respondent breached the confidentiality of several of her patients. She spoke with [redacted] father about personal confidences [redacted] had shared in therapy. She revealed to Patient N personal confidences that [redacted] had shared in therapy. In her office, patients had access to other patients' files. As a result, another patient tried to blackmail Patient E with information from her files.

501. "Management of appropriate psychiatric boundaries requires adequate training in psychodynamics, psychopathology, professional identity and roles, and issues related to gender and power differentials." Resp. exh. A27 at 430-431. (13 Review of Psychiatry 430-431 (J. Oldham & M. Riba, eds. 199-)).

502. Respondent's training, if any, in these areas, was minimal at best. She completed a two-year fellowship in child psychiatry but never received formal training in adult psychiatry.

503. "[T]he difference between a harmful and a nonharmful boundary crossing may lie in whether it is discussed or discussable" between the therapist and the patient. Resp. exh. A24 at 190. (Gutheil & Gabbard, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, 150 American Journal of Psychiatry 188, 190 (1993)).

504. This problem was apparent with several of respondent's patients. Patient O learned very quickly that there were some areas he was better off not discussing with respondent, including his feelings about craving drugs. He was also afraid to discuss the cross-dressing episode with respondent, because he feared that respondent would start yelling and screaming at him and would withhold his medication.

505. Patient C did not feel able to discuss with respondent her fears about writing the "dreaded report" on Patient D. Patient C did not feel able to air with respondent her concerns about her difficulty in managing Patient D. Patient C also felt she could not pursue with respondent the issue of Patient E's sedation in the bathtub after respondent told Patient C that Patient E needed the medications.

506. "The differences in impact [between benign or harmful boundary crossings] may depend on whether clinical judgment has

been used to make the decision, whether adequate discussion and exploration have taken place, and whether documentation adequately records the details." Resp. exh. A24 at 195. (Gutheil & Gabbard, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, 150 American Journal of Psychiatry 188, 195 (1993)).

507. Once again, respondent's practice lacked these essential attributes. The evidence in this case shows, time and again, the lack of adequate discussion and exploration of boundary issues with patients and the complete inadequacy of patient records.

508. "[T]he best risk management involves careful consideration of any departures from [the physician's] usual practice accompanied by careful documentation of the reasons for the departure. . . . [T]he value of consultation with a respected colleague should be a built-in part of every practitioner's risk-management program." Resp. exh. A24 at 196. (Gutheil & Gabbard, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, 150 American Journal of Psychiatry 188, 196 (1993)).

509. Here, respondent did not provide careful documentation of departures from usual practice and did not build into her practice the habit of consulting with respected colleagues. She had no risk-management program, according to the evidence presented.

510. Even apart from boundary issues, it is ethically imperative for a physician to "do nothing to diminish the dignity of any person or thing." Resp. exh. A128 at 16. (Curtis & Hodge, Old Standards, New Dilemmas: Ethics and Boundaries in Community Support, 18 Psychosocial Rehabilitation Journal 13, 16 (1994)).

511. The following ethical standards apply to provision of community support services in the rehabilitation context:

"1. The principle of beneficence. Promote good; do the right thing; enhance welfare.

2. The principle of non-malfeasance. Do no harm. Do not exploit one's position of power or influence for personal gain or against the will of a client.

3. The principle of autonomy. Focus on the centrality of the consumer. Promote and support consumer rights to choice and self-determination.

4. The principle of fairness and justice. Distribute resources equitably. Perpetuate individual civil and human

rights, including rights to privacy, dignity, and confidentiality. Fight against discrimination and stigma.

5. The principle of veracity. Provide accurate and clear information. Keep promises and agreements. Maintain personal and professional integrity.

6. The principle of informed consent. Provide information about options, risks, and potential consequences of choices. Explore options objectively.

7. The principles of privacy and confidentiality. Respect individuals' rights to control information about themselves.

8. The principle of competence. Ensure personal and professional competence of staff. Continue to develop skills and knowledge and apply them to work activities."

Resp. exh. A128 at 27. (Curtis & Hodge, Old Standards, New Dilemmas: Ethics and Boundaries in Community Support, 18 Psychosocial Rehabilitation Journal 13, 27 (1994)).

512. As the findings in this report show, respondent violated all of these ethical standards.

513. "Exploitative therapists . . . attack the self-esteem of their patients as a means of gaining control over them." Resp. exh. A25 at 148-149. (Simon, Treatment Boundaries in Psychiatric Practice, in Principles and Practice of Forensic Psychiatry 148-149 (R. Rosner, ed. 1994)).

514. Here, respondent gained control over Patient C by making her feel humiliated and degraded. Patient E's self-esteem was also undermined by respondent. Patient E felt like a "slave dog" after mowing respondent's lawn and receiving no payment for it.

515. "[P]sychotic and borderline patients are especially at risk for psychic injury [from boundary violations]. Many of these patients have been physically and sexually abused as children. Their sense of appropriate relationships and boundaries may be seriously impaired." Resp. exh. A25 at 149. (Simon, Treatment Boundaries in Psychiatric Practice, in Principles and Practice of Forensic Psychiatry 149 (R. Rosner, ed. 1994)).

516. Many of respondent's patients fit this description. Patients C, M, and O had histories of physical or sexual abuse. [redacted] had been physically abused by her ex-husband. These patients were therefore at special risk for psychological injury from respondent's boundary violations. Their treatment by respondent left several of these patients with lowered self-

esteem and a mistrust of treating professionals.

517. "Other kinds of relationships that coexist simultaneously with the physician-patient relationship have the potential to contaminate the physician's ability to focus exclusively on the patient's well-being and can impair the physician's judgment. . . . For example, financial relationships or business transactions may lead to resentment or dependency that interferes with the physician's ability to be empathic, sensitive, and selfless in the physician-patient relationship." Resp. exh. A23 at 1447. (Gabbard & Nadelson, Professional Boundaries in the Physician-Patient Relationship, 273 Journal of the American Medical Association 1445, 1447 (1995)).

518. Here, respondent entered into dual financial relationships with several patients, including Patients A, B, and E. Respondent bought personal items from Patient A when the patient was having financial difficulties. Respondent also managed Patient A's finances for a time. Respondent had Patient B perform clerical duties in the office, run errands, and tutor other patients for a minimal amount of money. Respondent agreed to be appointed guardian of Patient E, which would have given respondent legal control of Patient E's financial well-being.

519. "Given the emotional vulnerability of all psychiatric patients, the maintenance of appropriate boundaries is important regardless of the psychiatric treatment or technique employed." Resp. exh. A27 at 421. (13 Review of Psychiatry 421 (J. Oldham & M. Riba, eds. 199-)).

520. Regardless of what label is applied to respondent's practice methods (comprehensive psychiatry, comprehensive psychiatric rehabilitation, community psychiatry, or the like), respondent did not maintain appropriate boundaries with many of her patients and increased their emotional vulnerability to the extent that several of these patients now have difficulty trusting any physician.

521. The hearing committee supports well-administered programs of psychiatric rehabilitation and community psychiatry. However, the evidence in this case shows that respondent's attempts to apply the comprehensive psychiatric rehabilitation model to her own solo medical practice were misguided and reckless and resulted in sub-standard patient care.

522. She failed to establish or galvanize the community support systems that are necessary to make the model work. She lacked the necessary support personnel in her practice to make the model work. As a solo practitioner, she tried to do everything herself, from counseling patients to setting up their bank accounts. Even working overtime, she was unable to maintain adequate patient communications or medical recordkeeping.

Patient care suffered, resulting in the complaints that led to the charges in this case.

523. Respondent's own expert witness on "boundary" issues, Dr. Nancy Coyne, testified that poor and seriously mentally-ill patients require different treatment than middle-class, "normally" neurotic patients. This comprehensive type of treatment, just like methadone maintenance or detoxification, should not be attempted in a small private practice that lacks any type of support system. It should be tried only in a community mental health organization or larger setting that has a better support system.

524. The issue of boundary violations has become important in medical practice, so that physicians have to be very careful about how they interact with patients. It is particularly important for psychiatrists to be mindful of boundary issues, since patients may often misinterpret a psychiatrist's actions.

525. "[Professional boundaries in medical practice] are the parameters that describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service. Boundaries imply professional distance and respect . . .. While sexual contact is perhaps the most extreme form of boundary violation, many other physician behaviors may exploit the dependency of the patient on the physician and the inherent power differential. These include dual relationships, business transactions, certain gifts and services, some forms of language use, some types of physical contact, time and duration of appointment, location of appointments, mishandling of fees, and misuse of the physical examination." Resp. exh. A23 at 1445. (Gabbard and Nadelson, Professional Boundaries in the Physician-Patient Relationship, 273 Journal of the American Medical Association 1445 (1995)).

526. Respondent has not developed any general protocols to deal with boundary issues. She handles boundary issues on a case-by-case basis. Her ad hoc approach to boundary issues does not work. The evidence in this case shows that respondent was not careful at all about how she interacted with patients and that she disregarded their personal dignity and sensibilities.

527. Although many modern boundary rules are not rigid or inflexible, there is no justification for a psychiatrist slapping a patient in anger, screaming obscenities at a patient, or placing a patient with an improper caregiver.

528. Respondent actually pinpointed one of the problems with her own practice when she admitted that her type of practice places a drain on a small private practice lacking the funds for various activities, so that, in her opinion, the best possible

relationship would be if the private practice were able to contract with an agency that provided the necessary range of rehabilitation services.

529. Far from being an innovative new approach or positive career move, respondent's attempt to apply her comprehensive psychiatric rehabilitation practice model to a solo medical practice was one of the few avenues open to her once she left Rutland Mental Health Services and resigned her hospital privileges. It is evident that she had and still has difficulty working with other people. In the opinion of a former colleague in Pennsylvania, she had difficulty with non-medical people questioning her treatment recommendations. She also had difficulty abiding by the rules and requirements at Rutland Mental Health Services and Rutland Regional Medical Center. She has no professional colleagues with whom to consult. Voluminous testimony shows that she has a propensity to lose her temper, yell, swear, and belittle patients, employees, and others.

530. In contrast to more traditional types of psychiatric practice, community psychiatry and respondent's practice model depend upon a team approach. The many journal articles submitted by respondent underscore this point. Yet respondent conducted herself in a manner destructive of any team effort.

531. The types of patients treated by respondent are just as worthy of competent care as anyone else, yet they did not receive it from her. In fact, many of them suffered harm at her hands. They deserved better.

Conclusions of Law

A. (Count I) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

B. (Count II) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

C. (Count III) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and

proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

D. (Count IV) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

E. (Count V) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

F. (Count VII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

G. (Count VIII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

H. (Count IX) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

I. (Count X) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

J. (Count XI) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

K. (Count XII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

L. (Count XIII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(22), in that, in the course of her practice, she grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

M. (Count XIII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(6), in that she prescribed drugs for other than legal and legitimate therapeutic purposes.

N. (Count XIII) By her actions, respondent has committed unprofessional conduct as set forth in 26 V.S.A. § 1354(9), in that she willfully omitted to file or record medical reports required by law.

Opinion

Burden of Proof

Respondent argues that petitioner must prove by clear and convincing evidence that a violation of the standards of professional conduct has occurred. As support for her argument, respondent notes that proof of unprofessional conduct by attorneys must be shown by clear and convincing evidence.

In this state, the burden of proof in disciplinary matters before a professional licensing board is a preponderance of the evidence. See In re Lloyd Sutfin, D.D.S., No. AO-DE13-0395 at 5-6 (Office of the Secretary of State, Appellate Officer, Aug. 22, 1995); In re Muzzy, 141 Vt. 463, 472-473, 449 A.2d 970 (1982). The clear and convincing evidentiary standard for attorney discipline exists by administrative order of the Vermont Supreme Court, a separate branch of government. Vt. S. Ct. Admin. Ord.

No. 9, R. 13(C) (July 1, 1989); see also In re Berk, 157 Vt. 524, 527, 602 A.2d 946 (1991).

As the Supreme Court of Iowa noted in rejecting an argument identical to respondent's, "[t]he State is free to deal with different professions differently without violating the equal protection guarantees established under the federal and state constitutions. . . . This is particularly true where the regulations being compared have been established by different branches of government." Eaves v. Board of Medical Examiners, ___, Iowa ___, ___, 467 N.W.2d 234, 237 (1991).

Furthermore, even if the burden of proof were clear and convincing evidence, the facts of this case overwhelmingly support the determination that respondent's conduct was unprofessional on all counts set forth above in the conclusions of law.

Standard of Care

Respondent argues that "gross" failure to uphold the standard of care under 26 V.S.A. § 1354(22) requires a showing of failure to exercise even a slight degree of care, indifference to the duty owed, utter forgetfulness, and something more than an error in judgment. Emery v. Small, 117 Vt. 138, 140, 86 A.2d 542 (1952).

Since Emery was decided, the Vermont Supreme Court has rejected the concept of "gross" negligence because it provides a confusing and ineffective definition of duty. See Devo v. Kinley, 152 Vt. 196, 208, 565 A.2d 1286 (1989). "The Court's rejection of the word 'gross' in the standard was grounded in its belief that such language is misleading and might suggest to the trier of fact a standard of care higher than ordinary care." In re Peter L. Braun, D.M.D., No. DE16-0193 at 6 (Vt. Secretary of State, Appellate Officer, Sept. 29, 1994).

Nevertheless, the "gross" failure phraseology remains in § 1354(22). In the context of a professional licensing statute, the term "gross negligence" has been held to distinguish between gross or grave acts of negligence and less serious or more ordinary acts of negligence. Vivian v. Examining Board of Architects, 61 Wis. 2d 627, ___, 213 N.W.2d 359, 364 (1974).

Regardless of the legal viability of the "gross" failure phraseology, the hearing committee in this case found that, in those counts where "gross" failure was charged, respondent's conduct was extremely egregious and more serious than ordinary negligence.

Expert Evidence

Respondent argues that the hearing committee may not rely on the medical expertise of its physician member without corroborating or supporting expert witness testimony.

Physician members of medical boards are expected in physician disciplinary cases to use their experience and are not required to rely entirely on expert testimony to reach decisions involving medical practice issues. See Manthey v. Ohio State Medical Board, 36 Ohio App. 3d 181, ___, 521 N.E.2d 1121, 1125 (1987). It is well within the province of an administrative body such as the Board to apply its own expertise in the evaluation of the evidence presented at a disciplinary hearing and to accept or reject expert testimony proffered. Annot., 74 A.L.R.4th 969, 981 (1989). Application of this special expertise is one of the primary reasons for legislative creation of an administrative tribunal such as the Board.

In this case, the findings show that petitioner's expert witness, Dr. Dennett, presented entirely credible evidence in support of the charges. The hearing committee relied on his expert testimony, as well as on the extensive record of journal articles and other exhibits consistent with his testimony, to determine that respondent's conduct was unprofessional.

Lay Witness Evidence

Respondent objected to testimony by patients and their relatives about what she characterized as medical matters. Patients testified about what medicines had been prescribed for them, how they felt when they took the medication, and how they viewed the outcome of respondent's treatment. Some of the patients' family members testified about their observations of the patients while the patients were under respondent's treatment.

Under V.R.E. 701, lay witnesses may testify in the form of opinions or inferences if their testimony is rationally related to their perceptions and is helpful to a clear understanding of the testimony or the determination of the facts. Here, the testimony of the patients and their relatives was extremely important and helpful to the determination of the case. Their observations about their own treatment and what they experienced while under treatment provided the hearing committee with crucial information that supplemented and complemented other relevant testimony, including Dr. Dennett's review of their medical records.

Written Testimony

In the prehearing phase of these proceedings, the parties vetoed the use of prefiled written testimony. They represented to the Board that the case could be heard in eight days. After

the hearings began, it became evident to the hearing committee that the case could not be heard in the allotted time. The hearings eventually consumed 16 full days.

Of those 16 days, the hearing committee allotted fully one quarter of the time (four entire days) to respondent's testimony. This was longer than the time allotted to any other witness. In addition, the hearing committee permitted the parties to engage in liberal rounds of cross-examination, so that respondent was able to present much of her case that way.

After concluding 16 days of hearing, the hearing committee required the parties to file in writing any additional testimony they wished to present. Under 3 V.S.A. § 810(1), any part of the evidence in an administrative proceeding may be received in written form, when the hearing will be expedited and the interests of the parties will not be prejudiced substantially.

Here, the testimony that was received in written form consisted of evidence from witnesses who had already testified in person before the hearing committee during the 16 days of hearings. The hearing committee had the opportunity during their testimony to evaluate their credibility and observe their behavior on the witness stand. Therefore, requiring the parties to file any additional testimony in writing did not prejudice them.