COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.

Division of Administrative Law Appeals
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Docket No: RM-15-122

Date: July 8, 2016

BOARD OF REGISTRATION IN MEDICINE,
Petitioner

v.

ROBERT KOHN, M.D.,
Respondent

Appearance for Petitioner:

Tracy Morong, Esq.
Complaint Counsel
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

David M. Gould, Esq.
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Administrative Magistrate:

Angela McConney Scheepers, Esq.

RECOMMENDED DECISION

SUMMARY

The Respondent engaged in conduct that placed into question his competence to practice medicine in violation of 243 CMR 1.03(a)(a)3; engaged in conduct that undermined the public confidence in the integrity of the medical profession in violation of the standards set forth in *Raymond v. Board of Registration in Medic.*, 387 Mass. 708, 712 (1982) and *Levy v. Board of Registration in Medic.*, 378 Mass. 519 (1979); and engaged in misconduct in the practice of medicine in violation of 243 CMR 1.03(5)(a)18. I recommend that the Board impose such discipline on Dr. Kohn as it deems appropriate.

INTRODUCTION

On March 19, 2015, the Petitioner, Board of Registration in Medicine (Board), issued a Statement of Allegations ordering the Respondent, Robert Kohn, M.D., to show cause why (1) pursuant to G.L. c. 112, § 5 ninth ¶(c) and 243 CMR 1.03(5)(a)3 he should not be disciplined for conduct that placed into question his competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine with gross negligence on a particular occasion or negligence on repeated occasions; (2) why pursuant to 243 CMR 1.03(5)(a)(18) he should not be disciplined for misconduct in the practice of medicine pursuant to *Raymond v. Board of Registration in Medic.*, 387 Mass. 708, 712 (1982) and *Levy v. Board of Registration in Medic.*, 378 Mass. 519 (1979); and (3) why he should not be disciplined for conduct that undermined the public confidence in the integrity of the medical profession.

The Board alleges that on January 18, 2015, while employed at the Plymouth campus of High Point Treatment Center (High Point/Plymouth), the Respondent "[s]lammed his hand on the table where Patient V was seated"; [r]epeated pointed his finger within inches of Patient V's face; and leaned over table and pushed the table towards Patient V." (Allegation 10, Statement of Allegations.) "The Respondent then walked around the table, put his hand on Patient V's shoulder, leaned in towards her face, and spoke to her." (Allegation 11, Statement of Allegations.) The Respondent "[c]lutched Patient V's arm; [s]truck Patient V on the back with his hand"; dragged Patient V by the arm across the room"; gripped the back of Patient V's neck and [p]ushed Patient V's head onto a table." (Allegation 22, Statement of Allegations.)[1] This incident was recorded by a monitoring camera.

[1] The patients were referenced by diverse names in the exhibits. The parties agreed that Patient V would be used for the patient that was allegedly assaulted by Dr. Kohn. Patient 1 would be the name used for her roommate.

On March 23, 2015, the matter was referred to the Division of Administrative Law Appeals (DALA). DALA held a prehearing conference on May 11, 2015.

The Respondent filed an Answer to the Statement of Allegations on November 2, 2015. In his Answer, the Respondent denied the Board's allegations that he had departed from accepted medical practice. He denied that he slammed his hand on the table, pointed his finger within inches of the patient's face, leaned over the table and pushed the table into the patient, and that he pushed the patient's head into a table.

I held a hearing on November 4 and 5, 2015. I admitted joint Exhibits 1-15. Exhibits 1, 2, 3 and 6 were impounded. I marked the Petitioner's Statement of Allegations "A" for identification. I marked the Respondent's Answer "B" for identification.

The stenographic transcript serves as the official record of this hearing.

I allowed the Board's Motion for Sequestration of the Witnesses. The Board called Michele Young, R.N., a nurse at High Point Treatment Center/Plymouth; Michael Liebowtiz, M.D., the Chief of Psychiatry and Addiction Medicine at High Point Treatment Center's Middleborough campus; and subpoenaed Robert Pulsinelli, a former mental health specialist at High Point/Plymouth. The Respondent called Graham Spruiell, M.D., a psychiatrist, as an expert witness. Dr. Spruiell testified that the Respondent's treatment of the patient met the standard of care. The Respondent also testified on his own behalf.

The parties filed post-hearing briefs on January 8, 2016, whereupon the administrative record closed. I marked the Petitioner's post hearing brief "C" for identification and the Respondent's post hearing brief "D" for identification. The stenographic transcript serves as the official record of this hearing.

FINDINGS OF FACT

Based on the documents entered into evidence and the testimony of the witnesses, I make the following findings of fact:

1. Robert Kohn, M.D., was born on June 21, 1959. He graduated from the University of Illinois College of Medicine in 1985, and was licensed to practice in Massachusetts under certificate 58429 in 1987. Dr. Kohn is board certified in psychiatry, geriatric psychiatry and psychosomatic psychiatry. (Statement of Allegations; Testimony of Kohn.)

2. Dr. Kohn is a fluent Portuguese speaker and has experience working with Latino populations and homeless people. (Exhibit 12; Testimony of Kohn.)

3. Dr. Kohn is a consultant for the World Health Organization (WHO). He has worked in many Latin American countries and conducted research in Israel. Dr. Kohn was awarded a WHO collaborating center in psychiatric epidemiology and research, one of only two locations in the United States. (Exhibit 12; Testimony of Kohn.)

4. Dr. Kohn has also written publications for the WHO. The most recent ones are The Suicide Report for the Americas and The Treatment Gap, which focuses on the amount of services available in each country in the Americas. (Exhibit 12; Testimony of Kohn.)

5. Dr. Kohn has written two textbooks focused on the cultural issues in psychiatry. One text book is on the mental health of Brazil, and the other is on the mental health of Latin America and the Caribbean. (Exhibit 12; Testimony of Kohn.)

6. High Point Treatment Center (HPTC)'s Plymouth campus is a free-standing psychiatric hospital, consisting of the Inpatient Psychiatric Unit, the Dual Diagnosis Unit and the Detoxification Unit. (Statement of Allegations; Testimony of Kohn.)

7. HPTC's Emergency Code Policy was promulgated in October 2014. The Emergency Code's purpose was the following:

> Effective management of the environment of care includes processes and activities to reduce and control environmental hazards and risks; prevent accident and injuries; and maintain safe conditions for individuals served, visitors and staff. ... High Point Treatment Center (HPTC) uses a system of Emergency Codes where there is immediate need for staff assistance due to the following: ...
>
> - **Code Green – Behavioral Management Emergency**
>   - For Inpatient Units, only trained personnel should respond to Code Green and staff on each shift on each shift should be identified as a responder.
>   - The location of the emergency must be conveyed through the walkie-talkies when there is a need for the physical presence of code green responders and there is a concern for the safety of either staff or patients. If additional staff is required then an overhead building page should be done for further assistance. Often the physical presence of other staff members will be the only other action required. HPTC requires that all staff is trained in Non-Violent Crisis Intervention on hire with renewal yearly. ...
>
> Procedure. Persons Responsible.
> III. Code Green – Behavioral Management Emergency
>
> **A. All Staff**
> 1. Will call a **Code Green** using a walkie/talkie system when there is a risk of harm to either staff or patients;
> 2. Will state the location of the emergency when the code is being conveyed;
> 3. Will report to the **site of the emergency** immediately, if on designated response team;
> 4. Will use overhead page system in the event additional staff is needed; ...
>
> **B. Directors/Supervisors/Designees**
> 1. Will determine further action necessary;
> 2. Will determine when staff may return to their own work areas.

(Exhibit 6.) (Emphasis supplied.)

8. During a Code Green, all patients must report to their rooms. (Testimony of Kohn.)

9. According to Restraint and Seclusion in Facilities Licensed By, Contracted for, or Operated by the Massachusetts Department of Mental Health (DMH)[2] (Restraint and Seclusion Policy), High Point had to develop an Individual Crisis Prevention Plan (ICP) as soon as possible after admission, in consultation with the patient, legally authorized representative, and others when appropriate. If the patient refused to participate, the staff could develop the plan on its own. 103 CMR 27.12 (3)(b). The plan had to include:

- a list of all the triggers that might cause you to feel agitated or distressed;
- strategies to help you calm down and de-escalate the situation;
- your preferences, such as the type of restraint and positioning ,the gender of the staff person restraining you, and the ways in which you like to be calmed.[3]

(Exhibit 7; Testimony of Kohn.)

10. The Restraint and Seclusion Policy defines seclusion as:

> ... when you are placed against your will in a room so that you are prevented from leaving or believe that you cannot leave. ... These include situations in which you are threatened with coercive measures, such as threat of restraint, sanction, or a loss of privileges for leaving the room.[4]

Patients in seclusion had a staff member assigned to monitor them one-on-one (1:1).[5] Staff completed a form for each episode of seclusion: one copy for the patient's record, a second for the patient's comments; and the third for review by the DMH Commissioner. (Exhibit 7.)

11. The Restraint and Seclusion Policy defines restraint as including medication, mechanical or physical restraint. Physical restraint is defined as the following:

> ... holding you in a way that restricts your freedom of movement or normal access to the body. Physical restraint does not include non-forcible staff guiding you to

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2 Prepared by the Mental Health Legal Advisors Committee, January 2011. (Exhibit 7.)

3 104 CMR 27.12(3)(b).

4 104 CMR 27.12 (5)(a)(4)(a).

5 104 CMR 27.12(5)(h)(1).

> another area or taking reasonable steps to prevent an imminent danger (such as blocking a blow, breaking up a fight, or preventing a fall).[6]

(Exhibit 7.)

12. According to the Restraint and Seclusion Policy, during a restraint or seclusion, the patient must be placed in a position that allows airway access and does not compromise respiration[7]:

> **A face down position should not be used** unless you inform the staff that this is your preference (and there is no medical contradiction to its use) or there is an overriding psychological or medical justification for its use. This information needs to be documented.

(Exhibit 7.) (Emphasis in original.)

13. According to the Restraint and Seclusion policy, the facility director or facility medical director had to be notified any seclusion in excess of 5 hours or of two seclusions of a patient within 12 hours. In the event of any seclusion in excess of 12 hours or episodes in excess of 12 hours within a 48 hour period, the facility staff had to medically assess the patient; notify the facility directory and facility medical director who had to take additional steps; and report the episode to the DMH Commissioner ordesignee by the next business day. (Exhibit 7.)

14. According to the Restraint and Seclusion Policy, a patient had to be released from seclusion when the emergency no longer existed, or when upon examination, the patient appeared calm. Within 24 hours after seclusion, the patient had the opportunity to be debriefed and comment on the episode, which was then reviewed by the High Point Human Rights Officer. If the patient believed that she was illegally restrained, she could speak to the Human Rights Officer or file a written report to the person in charge of the program or facility. (*See* Finding of Fact 5; Exhibit 7.)

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6 104 CMR 27.12 (5)(a)(3)(c).
7 104 CMR 27.12 (5)(c)(2).

15. The Board's Policy 01-01 recognizes that disruptive physician behavior has a deleterious effect upon the health care system and increases the risk of patient harm.[8] The American Medical Association (AMA) has defined Disruptive Physician Behavior as a style of interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care. Behavior by a physician that is disruptive, and comprises the quality of medical care or patient safety could be grounds for Board discipline. Policy 01-01 concludes that physicians, in their role as patient and peer advocates, must recognize their obligation to speak out when faced with disruptive behavior. (Exhibit 14.)[9]

16. Some of the AMA Principles of Medical Ethics are especially applicable to psychiatry:

> *Section 1*
> *A psychiatrist shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.*
> 1. A psychiatrist shall not gratify his ... own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist. ...
>
> *Section 2*
> *A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence ...*
> 1. The requirement that the physician conduct himself ... with propriety in his ... profession and in all actions of his ... life is especially important in the case of the psychiatrist because the patient tends to model ... her behavior after that of ... her psychiatrist by identification. ... Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. ...

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8 Commonwealth of Massachusetts Board of Registration in Medicine Policy 01-01. (Adopted June 13, 2001.)

9 AMA H-140.918 Disruptive Physician Policy. (Exhibit 14.)

(Exhibit 11.)[10]

17. In addition to his geriatric psychiatry practice, Dr. Kohn "moonlighted" at High Point/Plymouth overnight every Tuesday and one weekend per month. (Testimony of Kohn.)

18. Dr. Kohn's employment at High Point/Plymouth was managed by Mark Hauser, M.D. and his corporation, On-Site Psychiatry Services Company. Dr. Kohn's Tuesday shifts began at 7:00 p.m. and ended at 7:00 a.m. His weekend shifts began on Fridays at 7:00 p.m. and ended on Sundays at 7:00 a.m. (Statement of Allegations; Testimony of Kohn.)

19. On Tuesdays, Dr. Kohn was responsible for all admissions at High Point's Inpatient Psychiatric Unit (IPU). On Fridays, he was again responsible for all admissions in the IPU. On Saturdays and Sundays, was responsible for admissions both in the IPU and the Dual Diagnosis Unit. On weekend, Dr. Kohn also rounded on all patients, meeting them in his office if necessary, adjusting their medications and discussing their medical issues with them. (Testimony of Kohn.)

20. On January 16, 2015, Patient V, a female, was a mental health patient at the IPU. She had a history of psychosis, drug abuse and trauma. (Exhibit 4; Testimony of Kohn.)

21. On January 16, 2015, Patient V's roommate was Patient 1. (Exhibit 4; Testimony of Kohn.)

22. Patient 1, a female drug abuser, had recently been released from a sentence for manslaughter and was in the IPU involuntarily. Patient was psychotic and confused, and on a methadone regimen. (Testimony of Kohn.)

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[10] American Psychiatric Association, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013 Ed.)

23. When Dr. Kohn reported for his weekend shift on Friday, January 16, 2015, he learned that Patient 1 had been placed on a 1:1 after she climbed into another patient's bed and assaulted her. The staff questioned Patient 1's placement at High Point because she was threatening other patients, appeared dangerous and was an inappropriate admission based on the services offered at High Point. In any event, Patient 1 could not be moved unless another hospital placement was available, but it was also outside Dr. Kohn's responsibilities to remove her. (Testimony of Kohn.)

24. Although Dr. Kohn met with the other patients in his office, he always met with Patient 1 in the hallway because he was concerned about being assaulted. (Testimony of Kohn.)

25. On Saturday, January 17, 2015, Patient 1 threatened other IPU patients. (Testimony of Kohn.)

26. Dr. Kohn met with Patient V that morning. Later in the day, Patient V had a tantrum because she wanted an entire bag of Jolly Rancher candies. Dr. Kohn met with her in his office, and Patient V agreed that she would have ten candies at a time in a Styrofoam cup. Patient V had another tantrum after her daughter had failed to visit. Dr. Kohn agreed that Patient V could call her mother, who had custody of the child due to the patient's substance abuse. Patient V's mother's refused to bring the child. (Testimony of Kohn.)

27. Patient V also tried to goad Patient 1 into violence. Tantrums continued throughout the day, with Patient V alternately insisting that Dr. Kohn had agreed to her having the entire bag of candies or having the child visit. Instead of remaining in his office, Dr. Kohn stayed on the unit floor and brought Patient V into his office to settle things down. He did this at least four times on Saturday. (Testimony of Kohn.)

28. Although every patient was required to have an ICP, that Saturday Dr. Kohn learned from the caseworkers that the psychiatrist responsible for the IPU during the week had not initiated one for Patient V. Typically that psychiatrist would create the plan in a treatment planning meeting with the nursing and case workers. (*See* Finding of Fact 9; Testimony of Kohn.)

29. During the afternoon of Saturday, January 17, 2015, Patient 1 was on her 1:1 when she wandered into a room commonly used to restrain people. The mental health worker (MHW) assigned to her followed into the room. Dr. Kohn was still on the floor of the unit when he walked by and saw the MHW cornered and Patient 1's arm raised with her fist cocked. Dr. Kohn approached Patient 1 from behind, grabbed her in a "bear hug" and moved her body to the bed. The MHW ran out of the room and never participated when Dr. Kohn called a Code Green. Dr. Kohn concluded that the MHW's panic was due to her lack of training. (Testimony of Kohn.)

30. Patient 1 was placed in four-point restraints and medicated. After she was removed from restraints, Patient 1 was placed on another 1:1 with a different MHW. (*See* Finding of Fact 9; Testimony of Kohn, Testimony of Pulsinelli.)

31. Patient 1 also attempted to hit a nurse on Saturday. Patient 1 also threatened Dr. Kohn, repeatedly telling him "she was going to beat his ass." Because she was on a 1:1, she had the ability to wander where she wanted and say threatening things. (Testimony of Kohn.)

32. Due to the tension on the floor created by Patient V and Patient 1, most of the other IPU patients were afraid and preferred to remain in their rooms. They only left to get extra medication from the nurses' station so they could sleep all day. (Testimony of Kohn.)

33. On Sunday, January 18, 2015, Dr. Kohn created an ICP for Patient V, mandating that she be placed in seclusion after she exhibited temper tantrums. According to this treatment plan, Patient V would not be rewarded with attention for out-of-control, exacerbating or goading behavior. (*See* Findings of Fact 9 and 23; Testimony of Kohn.)

34. Robert Pulsinelli, a MHW, was on duty on the afternoon of Sunday, January 18, 2015. (Testimony of Pulsinelli.)

35. Michele Young, a nurse manager who served as the evening campus supervisor of the Dual Diagnosis Unit nursing staff, was working on the afternoon of January 18, 2015. (Testimony of Young.)

36. Liz Torrance, R.N., and mental health specialists David Green and William Ryan were also on duty on the afternoon of January 18, 2015. (Exhibit 4.)

37. IPU patients socialize in the community room, the main congregation area for the patients. The community room is also called the TV room, the kitchen or the day room. A glass window from the nurses' station looks directly into the community room. The community room has one door that opens into the hallway by the nurses' station. (Exhibit 3; Testimony of Pulsinelli.)

38. On Sunday afternoon, January 18, 2015, Patient V's disruptive behavior continued. Instead of yelling and crying about having Jolly Rancher candies and seeing her child, she targeted other patients. In the community room, an African-American patient was watching "The Color Purple." Patient V used the remote control to turn off the television. At that time, Dr. Kohn consulted with the nurses, and gave Patient V a time out of spending thirty minutes in her room. Patient V went to her room on her own and spent thirty minutes there. (Testimony of Kohn.)

39. Patient V returned to the community room and began to taunt Patient 1. The argument moved into the hallway near the nurses' station, and one of the nurses asked Mr. Pulsinelli to separate them. Because of Patient 1's history and potential for violent behavior a Code Green was called at 4:15 p.m. Staff responded from various parts of the facility, including Dr. Kohn, Ms. Torrance, Mr. Green and Mr. Ryan. All patients were asked to return to their rooms. (Exhibit 4; Testimony of Kohn, Testimony of Pulsinelli.)

40. Per code protocol, the staff planned to take Patient 1 to the room she shared with Patient V, and a nurse asked Mr. Pulsinelli to take Patient V to the community room. Mr. Pulsinelli escorted Patient V to the community room at 4:19 p.m. and returned to the nurses' station. Patient 1 was combative and a lot of the staff was still engaged in trying to get her back to her room. (*See* Finding of Fact 4; Exhibit 4; Testimony of Pulsinelli.)

41. The staff tried to get the other patients from the community room to their rooms (standard procedure for a code) so that the community room could be a secured area. Patient V was sitting at one of the tables with a bowl and cup in front of her. From the hallway, Dr. Kohn could hear her arguing with other patients about why she should be allowed to leave the room as well. (*See* Finding of Fact 8; Testimony of Kohn.)

42. At 4:21 p.m., Dr. Kohn entered the community room, banged on the table where Patient V was sitting, pointed his finger in her face and told her she had to stay in the community room. Dr. Kohn leaned over the table as he yelled in Patient's V face, causing the table to be pushed into her. Patient V covered her face with her hands. Dr. Kohn walked around the table, placed his hand on Patient V's shoulder, leaned into her face and spoke to her. Leaving Patient V alone in the community room, Dr. Kohn left the door open and went into the hallway. (Exhibit 8; Testimony of Kohn.)

43. At 4:22 p.m., Patient V rose from the table and walked to the door, carrying a cup. Dr. Kohn entered the community room, left the door open, and Patient V backed into the room. Dr. Kohn asked Patient V where she was going, and she said that there were Cheerios back in her room. However, food for IPU patients is stored in the community room kitchen area. Dr. Kohn grabbed Patient's V cup and threw it on the floor. Patient V remained standing by the door. Dr. Kohn then walked over to the table where she had been seated, removed other plastic ware from the table and threw them in the trash can that was located further in the room. Patient V remained standing near the open door. Mr. Pulsinelli entered the community room and stood between Patient V and the open door. (Exhibit 8.)

44. At 4:22:29 p.m., Dr. Kohn clutched Patient V's arm, struck her on the back with his right hand and dragged her by the arm across the community room. He placed his left hand around her waist and then slid his hand up to the back of Patient V's neck. Dr. Kohn then stood behind Patient V and pushed her head onto a table. (Exhibit 8.)

45. The staff standing near the nurses' station heard a loud bang come from the community room. They entered and saw Dr. Kohn with his hand on the back of Patient V's neck as she was bent face down over the table. Ms. Young arrived from the Dual Diagnosis Unit in response to the Code Green. None of the staff intervened. Dr. Kohn was yelling at Patient V. Patient V was not struggling with Dr. Kohn. She was crying, yelling and appeared very upset to be in this position. As Mr. Green and Mr. Ryan approached to assist, Dr. Kohn walked away. (Exhibit 8; Testimony of Young.)

46. Patient V sat down at the table. Patient V said, "He hit me, he could not do that, that is illegal." Patient V was angry, crying and very emotional. She asked Ms. Young to sit with her. Ms. Young did not fear for her personal safety. She sat at the table and massaged

Patient 1's hands. When Patient said she wanted to speak to Ms. Young alone, Ms. Young asked the other staff to leave the room. Ms. Young offered Patient V a glass of water in order to calm her down. (Testimony of Young.)

47. At 4:23 p.m., Dr. Kohn returned to the room. He appeared very angry and gestured that Ms. Young should leave the room. When she did not comply, he put his arm around her upper arm and pointed to the door. Ms. Young left the community room, but continued to observe from the nurses' station window. Dr. Kohn approached Ms. Young later and informed her that he was upset that she had not left immediately when he asked her to. When Ms. Young replied that she had been trying to de-escalate the situation, Dr. Kohn advised her that was not her job that night. Ms. Young later learned of Patient 1's earlier aggressive behavior. (Exhibit 4; Testimony of Young.)

48. The events in the community room were recorded on High Point's monitoring system. (Exhibit 8.)[11]

49. In his January 18, 2015 progress notes of the incident, Dr. Kohn wrote at 4:00 p.m. that Patient 1 has "continuous intrusive behavior where she is demanding to have things only her way." He further described the incident as follows:

> 1st time patient [Patient V] threw a temper tantrum and would not allow patient(s) to watch their TV show. Patient was sent in a 30 minute time out. Later she then left time out. Targeted the same patient watching the same TV show and began screaming at her and having a temper tantrum.
>
> One of the patients who has been violent was triggered by the yelling and having flash backs and treated threatened to assault … [Patient V]. … [Patient V] continued to have a temper tantrum. Tried to leave the kitchen [community room] when she was told to stay in order that the dangerous patient could be moved. [Patient V] continued to scream and demanding and tried to leave the kitchen [community room] requiring MD [Kohn] to physically prevent her from leaving kitchen to prevent injury. The patient claimed she was leaving kitchen because

11 Both parties played the video during the November 2015 DALA hearing.

> she wanted to eat more cereal. She was prevented from doing so, as not to get assaulted. In the process she slapped MD in the stomach.[12]
>
> The patient was offered Thorazine 50 mg. She refused. Clonidine prn was taken.
>
> Patient was told she had to go again in timeout for 30 minutes. After the room was changed so that the violent patient was not in the same room. Then Patient's time out began.
>
> Plan
> Patient is having temper tantrums. Trying to get other patients upset. The patient should have 30 minute time outs. During that time she should not be engaged until after time out.

(Exhibits 10 and 10A.)

50. Before her shift ended that evening, Ms. Young contacted Marjorie Jean, the Area Director; Heather Brito, Clinical Director; and Kelli Jones, Nurse Manager. (Exhibits 1 and 4; Testimony of Ms. Young.)

51. On January 19, 2015, Ms. Brito reviewed the video tape with Dr. Luis Molmenti, the Chief of Psychiatry Services; Dr. Michael Liebowitz, Chief of Psychiatry Addition Medicine; and Mary Ann Foose, Director of Nursing. (Exhibits 1 and 4; Testimony of Dr. Liebowitz, Testimony of Ms. Young.)

52. Dr. Liebowitz contacted Dr. Hauser and requested that he not assign Dr. Kohn to High Point until the investigation was concluded. Dr. Liebowitz had studied under Dr. Kohn during his psychiatry residency at Brown University's School of Medicine. (*See* Finding of Fact 3; Exhibits 1 and 4; Testimony of Dr. Liebowitz.)

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[12] Dr. Kohn testified that this slap occurred outside the range of High Point's cameras that recorded the January 18, 2015 incident. I do not find Dr. Kohn's testimony about the slap to be credible.

53. Ms. Jean initiated an investigation immediately. She interviewed Ms. Torrance, Mr. Green and Mr. Ryan. Patient V declined to file a complaint with the High Point Human Rights Officer. (Exhibit 4.)

54. Ms. Jean reviewed the January 19, 2015 client incident report form completed by Stefanie Kruger, R.N. Ms. Kruger wrote:

> Pt. heard yelling in TV room, I saw thru the med room window … Dr. Kohn and the pt. yelling at each other. 3-11 supervisor Michelle Young tried to intervene by talking calmly with Pt. Doc then ordered her out of room. The screaming continued and the doc physically directed Pt. down on table by the neck. Pt. yelled, "You are hurting me." Doc ordered Pt. "to room for 30 min. time out." Nurses not allowed to intervene.

(Exhibits 1, 4 and 9.)

55. On January 26, 2015, Ms. Jean, Dr. Liebowitz, Ms. Foose, Dr. Hauser and Ms. Jean spoke via teleconference. They decided that DMH had to be informed, that Dr. Kohn had to be removed from the schedule and that there would be an upcoming peer review with the Executive Committee of the Professional Staff (Executive Committee) to discuss the investigation and make recommendations. (Exhibits 4 and 5.)

56. On January 28, 2015, Ms. Jean telephoned Liz Kinkead, R.N., the DMH Director of Licensing, to inform her of the incident. Ms. Jean sent Ms. Kinkead a summary of the investigation the following day. (Exhibit 4.)

57. The Executive Committee met on February 24, 2015. The committee was aware that Patient 1 had a trauma history. After a peer review by five physicians, the Executive Committee decided that Dr. Liebowitz would inform the Board of the January 18, 2015 incident, and that Dr. Kohn's privileges would be suspended pending the Board's decision. The Executive Committee informed Daniel Mumbauer, High Point President and CEO, and Fran Markle, Vice

President and COO, of its decision. Ms. Jean informed Ms. Kinkead at DMH of the Executive Committee's decision. (Exhibits 1, 5 and 11.)

58. A health care facility's curtailment of a physician's activity as defined by 243 CMR 3.02 is reportable to the Board, pursuant to M.G.L. c. 111, § 53B. By letter dated February 27, 2015, Dr. Liebowitz informed the Board of the January 18, 2015 incident. He further reported that Patient V had a trauma history and that Dr. Kohn's behavior was not in keeping with acceptable medical practice. (Exhibits 1 and 14.)

59. Dr. Liebowitz later submitted the Health Care Facility Disciplinary Action initial report to the Board on March 11, 2015. In his description of the January 18, 2015 incident, Dr. Liebowitz wrote:

> Inappropriate aggressive physical contact with a patient on an inpatient psychiatric unit. Verbally berating a patient, slamming his hand onto a table, grabbing patient and forcing her head onto a table. Patient posed no imminent threat to Dr. Kohn, staff or any other patients.

(Exhibit 13.)

60. The Board referred the matter to DALA for recommended findings of fact and necessary conclusions of law on March 20, 2015.

DISCUSSION

A. Legal Standards

After a careful review of all the evidence in this case, I have concluded that the Board met its burden of proof with respect to the allegations that the Respondent engaged in conduct that placed into question his competence to practice medicine, committed misconduct in the practice of medicine and engaged in conduct that undermined the public confidence in the integrity of the medical profession. As such, the provisions of G.L. c. 112, § 5 ninth ¶(c), 243 CMR 1.03(5)(a)3, 243 CMR 1.03(5)(a)(18) and precedent pursuant to *Raymond v. Board of*

Registration in Medic., 387 Mass. 708, 712 (1982) and *Levy v. Board of Registration in Medic.*, 378 Mass. 519 (1979) are applicable in this case.

A clear preponderance of the evidence supports the Board's Statement of Allegations that on January 18, 2015 at High Point/Plymouth, the Respondent berated a patient, slammed his hand on a table in a highly agitated state, yelled directly in the patient's face while pointing his finger in her face, grabbed the patient by the neck, bending her over and forcing her head on a table. At the time of the incident, the patient did not present an imminent threat to herself, any patient, Dr. Kohn or other staff.

Pursuant to G.L. c. 112, § 5 ninth ¶(c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to the Board that the physician engaged in conduct that placed into question his competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine with gross negligence on a particular occasion or negligence on repeated occasions.

Pursuant to 243 CMR 1.03(5)(a)(18), the Board may discipline a physician upon proof satisfactory to the Board that the physician has committed misconduct in the practice of medicine.

Pursuant to *Raymond v. Board of Registration in Medic.*, 387 Mass. 708, 712 (1982) and *Levy v. Board of Registration in Medic.*, 378 Mass. 519 (1979), the Board may discipline a physician upon proof satisfactory to the Board that the physician engaged in conduct that undermined the public confidence in the integrity of the medical profession.

B. The Respondent's Conduct Qualified as Disruptive Behavior and Professional Misconduct

According to the Restraint and Seclusion Policy, staff "may use restraint and seclusion only in cases of emergency and in compliance with strict standards." The Restraint and

Seclusion Policy defines physical restraint as holding an individual in a way that restricts the individual's freedom of movement or normal access to the body. A patient should not be put into a restraint face down because there is always a risk that of obstruction to a patient's airway.

The Board's Policy 01-01 recognizes that disruptive physician behavior has a deleterious effect upon the health care system and increases the risk of patient harm. Disruptive behavior is a style of interaction such as foul language; rude, loud or offensive comments; and intimidation with physicians, hospital personnel, patients, family members, or others that interferes with patient care.

The Respondent was recorded exhibiting disruptive behavior during the incident at the heart of this matter on January 18, 2015. Dr. Kohn slammed his hand onto the table where Patient V was seated; leaned over the table while yelling at her and pointing his finger in her face, causing the table to be pushed into Patient V. When Dr. Kohn threw Patient V's items in the trash and on the floor, such actions constituted inappropriate behavior for a psychiatrist on an inpatient unit. The recording was corroborated by the credible testimony of the Board's witnesses.

C. *Respondent's Argument*

In his Answer, Dr. Kohn denied that he slammed his hand on the table, pointed his finger within inches of Patient V's face, leaned over the table and pushed it into Patient V, and that he pushed Patient V's head onto the table. Dr. Kohn also denied that he departed from acceptable medical practice.

During the hearing at DALA, the video documented the events as they transpired on January 18, 2015. Unable to deny the conduct that was clearly depicted in the video, Dr. Kohn proceeded on the argument that his actions were appropriate given their context within the IPU that weekend, the lack of properly trained MHWs and the potential for danger presented by the presence of Patient 1.

Not only did Dr. Kohn testify that the MHWs were untrained, he stated that High Point's security was lax in comparison with the other psychiatric facilities he served. He testified that other psychiatric hospitals had security officers to assist with codes. Instead, High Point had no security staff and there was rapid turnover among the hospital staff. He testified that most of the High Point staff had been substance abusers themselves, and were eligible for employment at High Point after being clean for only two years. The Respondent testified that this lack of experience among the staff impacted his work, and that on any given shift, he didn't know how competent the staff would be. I find that Dr. Kohn's testimony of the lack of staff training was not credible.

From the Restraint and Seclusion Policy, it is undisputed that Dr. Kohn's actions towards Patient V were not an appropriate restraint. I reject Dr. Kohn's testimony that his conduct was exempted due to an exception in the Restraint and Seclusion Policy which allows staff to non-forcibly guide a patient to another area or "reasonable steps to prevent an imminent danger (such as blocking a blow, breaking up a fight, or preventing a fall)." Dr. Kohn's conduct as exhibited in the video was not non-forcible.

The Board argued and the video shows that at the time of the incident, Patient V presented no danger to herself, another patient, staff or Dr. Kohn. The door to the community room was open, staff was present in the community room or mere short steps away in the hallway near the nurses' station. At the time that Dr. Kohn threw away Patient V's plastic ware, Patient V presented no danger. When Dr. Kohn grabbed Patient V's arm and manhandled her further into the community room, she presented no danger. When he grabbed her neck and forced her down on the table, she presented no danger. In a shadow of his rear "bear hug" of Patient 1, Dr. Kohn forced Patient V face down on the table, in spite of the prohibition against face down restraints.

Dr. Kohn argued that he was protecting Patient V from an "imminent danger," as manifested in the form of Patient 1. Dr. Kohn testified that Patient 1 was an involuntary commitment, was dangerous, was threatening and on a methadone regimen. Patient 1had recently been released after serving a sentence for manslaughter and was an inappropriate admission for the services available at High Point. Dr. Kohn did not have authority to have her moved to another psychiatric facility.

Dr. Kohn testified that when Patient 1 was placed on a 1:1, she used it as liberty to berate other patients more than usual. She attempted to strike a nurse on Saturday, January 17, 2015; she threated Dr. Kohn that "she was going to beat his ass."

.Dr. Kohn testified that around 4:00 p.m., he was concerned again about the potential for violence. He requested that Patient V go into the community room in an effort to keep Patient 1 and Patient V separated. Dr. Kohn requested the other patients to leave the community room so that he could secure the area. Dr. Kohn testified that he slammed his hand on Patient V's table because the situation was "an emergency crisis," wanted to prevent Patient V from leaving the community room, and wanted to keep her safe. Dr. Kohn testified that he slammed his hand on the table at 4:21 p.m. in order to get Patient V's attention, rather than threaten her. However, this argument of imminent danger fails because by 4:21 p.m., Patient 1was back in her room at the time the incident unfolded. Thus, she presented no danger to Patient V.

Dr. Kohn testified that when Patient V later stepped into the hallway, she struck him in the stomach. This is not recorded, and none of the staff observed it. I do not find Dr. Kohn testimony about the slap to the stomach to be credible.

Dr. Kohn testified that he snatched Patient V's cup and threw it to the floor in response to the alleged slap to the stomach – a violation of APA principles that require the physician to conduct himself with propriety in his profession. In response to the alleged potential for violence and chaos, Dr. Kohn modeled aggressive and hostile behavior. The APA principles stress that a psychiatrist's decorum is "especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate ... both patient and psychiatrist, while weakening the objectivity necessary for control."

When Dr. Kohn took Patient V's plastic ware from the table, walked to the trash and threw them away – he turned his back on Patient V as she stood near the doorway. If there was a threat of imminent harm just outside the community room, it would not be appropriate for the Respondent to turn his back on Patient V because it would give her ample opportunity to escape.

Dr. Kohn claimed that he put his hands on Patient V because, when he tried to lead her back into the community room, "she fought me. She tried to leave, get away from me." Dr. Kohn "asked her to go back to her chair, where she was before. She wouldn't, okay? In terms of she just struggled with me and the situation ended up where it ended up, not intentionally, but you know, you know, so but I was trying to get her in the chair ..." Dr. Kohn claimed that that his touching of Patient V was a legitimate restraint.

Dr. Kohn characterized his physical contact as a "hold." Dr. Kohn agreed that a hold is defined as touching "a patient without undue force in order to calm her." However, he admitted that he did not place his hands on the back of Patient V's neck in an effort to calm her.

D. The Board's Witnesses were Credible and Unbiased

Dr. Liebowitz had trained as a psychiatric resident under the Respondent at the Warrant Alpert Medical School of Brown University. He respected Dr. Kohn and viewed him as a mentor. He was shocked at the Respondent's behavior and pained that he had to testify against his former professor.

A mandated reporter, Dr. Liebowitz, had the task of informing the Board of the incident.

Dr. Liebowitz credibly testified that there was always adequate staff at High Point and that all staff members have been trained in de-escalation techniques and approved forms of physical restraint. He testified that not only was pushing Patient V face down on the table a violation of the Restraint and Seclusion Policy, grabbing Patient 1 from behind in a "bear hug" was also inappropriate.

Mr. Pulsinelli and Ms. Young were credible and showed no bias. They enjoyed working with Dr. Kohn and respected him. They testified that his behavior on January 18, 2015 was out of character of the psychiatrist that they knew.

Mr. Pulsinelli, a MHW, was the only witness to Dr. Kohn's assault on Patient V. He testified that at approximately 4: 19 p.m., he stood with Dr. Kohn at the nurses' station outside the community room as other staff escorted Patient 1 back to her room.

Mr. Pulsinelli was standing in the hallway outside the community room when he heard yelling and arguing inside from inside and a loud bang. Someone told Mr. Pulsinelli to go into the community room. Mr. Pulsinelli entered the room and stood by the door. Patient V did not try to leave the room. Mr. Pulsinelli testified that the Respondent hit Patient V. Mr. Pulsinelli further testified that the Respondent grabbed Patient V and then pushed her down onto a table.

Mr. Pulsinelli's credible testimony proved that Dr. Kohn hit Patient V, and was corroborated by the video.

Michele Young testified that on Sunday afternoon, she responded to a Code Green on the IPU. She could hear raised voices coming from the community room before she entered. At the time she entered, Patient 1 was back in her room and Patient V was not in danger from her. Ms. Young found that Dr. Kohn was angry, while Patient V was sad, emotional and crying. Ms. Young was concerned because Patient V was face down in violation of the Restraint and Seclusion Policy. She was not in fear of her safety, and remained alone in the community room with Patient V until Dr. Kohn made her leave. Ms. Young testified that before the incident, she enjoyed working with Dr. Kohn because he was very responsive to patients and staff.

The harm to Patient V, according to the Dr. Kohn's version of events, was that Patient V was attempting to leave the Day Room and engage with Patient 1. In contrast, Mr. Pulsinelli, Dr. Liebowitz and Ms. Young testified that Patient V was not in harm's way.

E. Expert Testimony

Dr. Kohn called Graham Spruiell, M.D., as a medical expert. Dr. Spruiell testified that Dr. Kohn was not restraining Patient V, but was trying to protect her from harm. However, I discount that testimony because Dr. Kohn testified that he was trying to restrain Patient V.

F. Aggravating Facts

The physician-patient relationship requires sound professional judgment, an acute sensitivity to the trust placed in the physician and a high degree of integrity. The practice of psychiatry necessitates an even heightened awareness of these dynamics, as a unique power imbalance exists within this field of medicine. *In the Matter of Jeffrey S. Shapiro, M.D.,* Board of Registration in Medicine, Adjudicatory Case No. 99-10-DALA (Final Decision and Order, February 9, 2000); *In the Matter of Edward E. Gilmour, M.D.,* Board of Registration in Medicine, Adjudicatory Case No. 98-35-DALA (Final Decision and Order, July 28, 1999). As such, the psychiatrist must guard against using his position in a manner that would jeopardize a patient's physical, mental or financial well-being. *In the Matter of Gerald M. Aronoff, M.D., Board of Registration in Medicine*, Adjudicatory Case No. 91-5-DALA (Final Decision and Order, June 18, 1992); *In the Matter of Donald M. Allen, M.D.,* Board of Registration in Medicine, Adjudicatory Case No. 407 (Final Decision and Order, December19, 1980).

In the present matter, a unique power imbalance existed between an inpatient mental health patient and her psychiatrist. The Respondent failed to show a high degree of integrity, sound professional judgment or an acute sensitivity in his behavior towards Patient V, a woman who suffered from trauma in the past.

CONCLUSION

Based on the foregoing, I find that pursuant to G.L. c. 112, § 5 ninth ¶(c) and 243 CMR 1.03(5)(a)3, the Respondent engaged in conduct that placed into question his competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine with gross negligence on a particular occasion or negligence on repeated occasions; (2) pursuant to 243 CMR 1.03(5)(a)(18) the Respondent committed misconduct in the practice of medicine pursuant to *Raymond v. Board of Registration in Medic.*, 387 Mass. 708, 712 (1982) and *Levy v. Board of Registration in Medic.*, 378 Mass. 519 (1979); and (3) engaged in conduct that undermined the public confidence in the integrity of the medical profession.

The Board's witnesses testified that Dr. Kohn was a good psychiatrist and that he was caring of his patients. They all expressed surprise of his behavior as transpired on January 18, 2015, and testified that it was completely out of character. Dr. Kohn has worked with socially and linguistically marginal populations and written extensively on mental health in Latin American and the Caribbean.

Indeed I have listed aggravating factors in this decision. While I do not accept Dr. Kohn's argument for his behavior that evening and am cognizant of Patient V's trauma history, the evidence does show that it was an unusually tense weekend at High Point/Plymouth. I ask the Board to consider all factors as it metes out discipline.

Accordingly, I recommend that the Board impose such discipline on Dr. Kohn as it deems appropriate.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Angela M. McConney Scheepers

Angela McConney Scheepers
Administrative Magistrate

DATED: JUL - 8 2016