COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2013-017

In the Matter of

RAYMOND W. KAM, M.D.

**CONSENT ORDER**

Pursuant to G.L. c. 30A, § 10, Raymond Kam, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 12-241.

Findings of Fact

1. The Respondent-was born on November 26, 1969. He graduated from the Yale University School of Medicine in 1996. He is certified by the American Board of Psychiatry and Neurology in Psychiatry and in Child and Adolescent Psychiatry. He has been licensed to practice medicine in Massachusetts under certificate number 155699 since 1997.

2. Since completing his training in 2002, the Respondent worked in the community and outpatient psychiatry clinics at Children's Hospital Boston (Children's Hospital).

3. From January 2011 to April 2012, the Respondent also worked in the outpatient psychiatric clinic at Children's Hospital where he supervised child psychiatry fellows.

The Respondent's Pre-hospitalization Treatment of Patient A

4. From August 2011 to April 2012, Patient A was seen in Children's Hospital outpatient clinic by a psychiatry fellow. The psychiatry fellow was supervised by her supervisory attending. The supervisory attending did not attend treatment sessions with the fellow and Patient A, but reviewed the fellow's treatment notes and met with the fellow weekly to discuss Patient A.

5. Patient A was suffering from several serious psychiatric symptoms and/or conditions.

6. In the late summer/early fall 2011, Children's Hospital categorized Patient A as a psychopharmacological patient.

7. In October 2011, the Respondent became involved in Patient A's care and attended two of Patient A's sessions with the psychiatry fellow.

8. Patient A, who had been difficult to engage, appeared to communicate more easily with the Respondent in attendance.

9. In January 2012, Patient A's outpatient visits increased in frequency and the Respondent and psychiatry fellow together saw Patient A.

10. In January 2012, the Respondent printed parts of Patient A's medical records and retained them at his home for several months when he sought permission from Patient A's father to retain the records.

11. During one of Patient A's outpatient visits which occurred prior to her hospitalization, the Respondent became concerned with Patient A's spiritual wellbeing. He believed that Patients A's problems were not only the result of her psychiatric symptoms and/or conditions, but were also spiritual in nature.

12. Without mentioning Patient A by name, the Respondent told some members of his church that he was treating a patient and that he had concerns about that patient's spiritual wellbeing.

Patient A's Hospitalization

13. From on or about February 8, 2012 to February 23, 2012, Patient A was hospitalized in Children's Hospital's psychiatric inpatient unit. While hospitalized, Children's Hospital employees entered Patient A's room to conduct five minute wellness checks.

14. On February 8, 2012, the Respondent came to believe that there was a significant spiritual component to Patient A's symptoms and condition. During Patient A's hospitalization, the Respondent told Patient A about his belief.

15. The Respondent visited Patient A approximately three times while she was hospitalized. During a part of each visit with Patient A, the Respondent was accompanied by the psychiatry fellow. During the entire time of each visit, Children's Hospital employees conducted five minute wellness checks on Patient A.

16. During Patient A's hospitalization, the Respondent failed to tell Patient A's inpatient treaters about his belief that there was a significant spiritual component to Patient A's symptoms and conditions. However, the Respondent did communicate this to the psychiatry fellow and to the fellow's direct supervisor.

17. On February 14, 2012, the Respondent gave Patient A a cross in exchange for a different religious symbol that she was wearing. The Respondent believed that Patient A believed the symbol was harmful to Patient A and believed that the exchange would help Patient A. Patient A later returned the cross to the Respondent.

18. On February 15, 2012, the Respondent reached the conclusion that he could no longer be part of Patient A's treatment team and shared his understanding of Patient A's condition

with the psychiatry fellow and notified the psychiatry fellow that he was signing off the case and, in fact, later did so.

19. On February 17, 2012, the Respondent met with the psychiatry fellow and the fellow's supervisor, a senior practitioner at Children's Hospital and someone who had previously been the Respondent's supervisor and mentor, to discuss the case with him. At this meeting, the Respondent shared his understanding of Patient A's condition with the psychiatry fellow's supervisor and they discussed Patient A's spiritual needs as well as her continued psychiatric treatment at Children's Hospital. They also discussed the Respondent taking on the role of Patient A's spiritual mentor. The psychiatry fellow's supervisor also instructed the Respondent to seek a consultation for Patient A from his own church. The supervisor also directed and introduced the Respondent to a Children's Hospital Christian chaplain for spiritual consultation.

20. On or about February 17, 2012, the Respondent offered to Patient A to become her spiritual mentor.

Patient A's Post-Hospitalization Treatment and Relationship with the Respondent

21. After Patient A was discharged from Children's Hospital, she continued to receive treatment from the psychiatry fellow and the fellow's supervisor at Children's Hospital's outpatient clinic.

22. After Patient A's discharge, the Respondent obtained consent via email and later in person from Patient A's father to act as her spiritual mentor. Subsequently, the Respondent brought Patient A to his church and to church related meetings.

23. The Respondent introduced Patient A to some of the same church members with whom he had discussed a patient prior to her hospitalization.

24. During the same time period, the Respondent communicated with Patient A on a regular basis, often by text message which were of a personal nature.

25. The Respondent met with Patient A, members of his church and an assistant minister of his church to develop a plan to address Patient A's alleged spiritual issues.

26. The Respondent met with a Children's Hospital's chaplain to develop a plan to address Patient A's alleged spiritual issues.

27. In March 2012, Patient A told the Respondent that her father had evicted her from her home and that she had nowhere to stay at night.

28. The Respondent failed to report to any state agency that Patient A had told him that she had been evicted from her home. Instead, the Respondent and his wife invited Patient A to stay overnight at his home with their family which she did. Subsequently, the Respondent obtained permission from Patient A's father, and she stayed overnight at his home with his wife and family on three more occasions.

29. In March 2012, Patient A told the Respondent that her mother had pushed her down a flight of stairs and had tried to asphyxiate her.

30. The Respondent had reason to believe that Patient A was suffering injury resulting from abuse and never reported to the Department of Children and Families that he had reason to believe that Patient A was suffering injury resulting from abuse.

31. The Respondent imparted his own religious system of belief to Patient A.

32. The Respondent failed to separate his own religious belief for diagnostic concepts and therapeutic practice.

33. According to the American Psychiatric Association's *Guidelines Regarding Possible Conflict Between Psychiatrist's Religious Commitments*, "psychiatrists should not impose their own religious systems of belief on their patients nor should they substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice."

## Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, ninth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine.

B. The Respondent has violated 243 CMR 1.03(5)(a)18 by committing misconduct in the practice of medicine.

C. The Respondent has violated G.L. c. 112, § 5, ninth par. (b) and 243 CMR 1.03(5)(a)2 by committing an offense against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder—to wit:

> 1. G.L. c.119, §51A which state states that a physician who "has reasonable cause to believe that a child is suffering physical or emotional injury resulting from: . . . abuse . . . shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect . . . ."

D. The Respondent has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982).

## Sanction and Order

The Respondent's license is hereby indefinitely suspended. The suspension may be stayed after a period of 24 months retroactive to June 25, 2012. Any stay of the suspension will be at the Board's discretion and will be contingent upon the Respondent: completing an independent forensic psychiatric evaluation by a Board-approved psychiatrist, showing that he is fit to practice medicine and, more specifically, psychiatry; completing a clinical skills assessment by a Board-approved program to assess the Respondent's ability to practice adult, child, and adolescent psychiatry and his

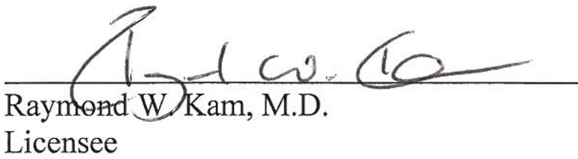
ability to maintain boundaries and comply with the American Psychiatry Association's guidelines regarding religious conflict; entering into a five-year Probation Agreement. Both the psychiatric evaluator and the skills assessment entity shall make recommendations as to any conditions that they deem to be necessary for the Respondent's safe return to practice. The Probation Agreement shall include all conditions that the Board deems appropriate at the time including, but not limited to: any recommendations of the psychiatric evaluator; any recommendations of the skills assessment entity; a Board-approved practice plan; monitoring by a Board-approved psychiatrist who is certified by the American Board of Psychiatry and Neurology in adult, child, and adolescent psychiatry - on a monthly basis, the monitor will review ten of the Respondent's cases at random and meet with the Respondent regarding those cases in order to ensure that the Respondent is maintaining proper boundaries and providing his patients with adequate care; and the Monitor will file monthly reports with the Board and make any recommendations to the Board regarding the Respondent's practice that he or she deems necessary.

Execution of this Consent Order

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also

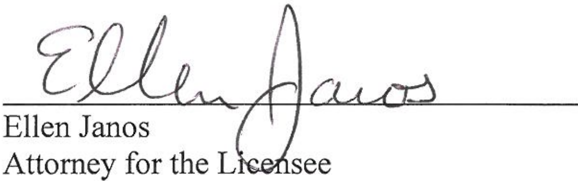
provide this notification to any such designated entities with which he becomes associated for the duration of this suspension. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.



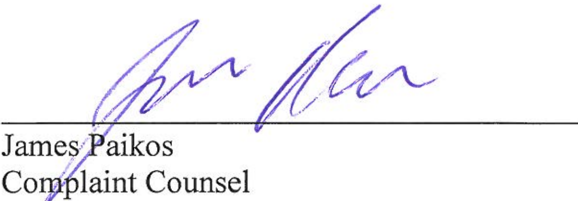
Raymond W. Kam, M.D.
Licensee

4/18/2013
Date



Ellen Janos
Attorney for the Licensee

4/18/13
Date



James Paikos
Complaint Counsel

4/22/13
Date

So ORDERED by the Board of Registration in Medicine this 8th day of May, 2013.

Candace Lapidus Sloane, MD
Candace Lapidus Sloane, M.D.
Board Chair



SENT CERTIFIED MAIL 5/8/13 (mg)