COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2013-018

In the Matter of	)
ENRICO MEZZACAPPA, M.D.	)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Enrico Mezzacappa, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice, as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 12-243.

Biographical Information

1. The Respondent was born on November 7, 1953. He graduated from the Catholic University of the Sacred Heart in Rome, Italy in 1982. 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 56566 since 1986. He has privileges at Children's Hospital Boston (Children's Hospital).

Factual Allegations

The Respondent's Pre-Hospitalization Involvement with Patient A ,

2. In Summer 2011, Patient A was a sixteen year-old female suffering from several serious psychiatric symptoms and/or conditions.

3. Patient A and her mother practiced a non-Christian faith.

4. In Summer 2011, a second year psychiatric fellow (Fellow) began treating Patient A in Children's Hospital's psychiatric outpatient clinic.

5. The Respondent was the senior attending psychiatrist assigned to supervise the Fellow in her treatment of Patient A.

6. The Respondent was responsible for meeting with the Fellow to discuss her treatment of Patient A.

7. The Fellow wrote treatment notes of every meeting she had with Patient A.

8. The Respondent reviewed and signed all of the Fellow's treatment notes regarding Patient A.

9. Children's Hospital did not require the Respondent to be present in the outpatient clinic when the Fellow met with Patient A.

10. The Respondent never met or spoke with Patient A.

11. There were psychiatric attendings, referred to by Children's Hospital as attendings-of-the-day, present in the outpatient clinic and available to directly supervise psychiatric fellows while they saw patients. The Respondent had no official supervisory role as to these attendings-of-day nor did he see patients in the clinic in his role as the Resident Director.

12. On or about October 11, 2011, the Fellow asked the attending-of-the-day present to meet with her and Patient A (the Attending). The Attending became involved in the treatment of Patient A.

13. From on or about October 11, 2011 to February 2012, the Attending and the Fellow met Patient A together.

14. The Fellow told the Respondent that the Attending was very involved with the patient and may be losing objectivity.

15. The Fellow and the Respondent discussed whether it was necessary at that time for the Respondent to speak with the Attending. The Fellow indicated that the patient seemed to be benefiting from working with the Attending and that she was learning from observing the Attending treat the patient.

Patient A's Hospitalization

16. From on or about February 8, 2012 to February 23, 2012, Patient A was hospitalized in Children's Hospital's psychiatric inpatient unit.

17. During Patient A's hospitalization, Patient A's care became the primary responsibility of her inpatient psychiatric team.

18. On February 8, 2012, the Attending met alone with Patient A.

19. As a result of his February 8, 2012 meeting, the Attending came to believe that Patient A was being influenced by, speaking with, and being hurt by evil spiritual entities.

20. The Attending also believed that Patient A's symptoms and conditions were not psychiatric in nature but were caused by evil spirits (hereinafter referred to "the spiritual diagnosis.")

Discussions Involving the Respondent, the Attending, and the Fellow

21. On or about February 17, 2012, the Attending told the Respondent about the exchange of religious symbols between himself and Patient A on the inpatient unit on February 14, 2012. The exchange of religious symbols is recorded in the inpatient team progress note by the inpatient attending.

22. The Attending told the Respondent about his belief that Patient A was influenced by, spoke with, and being physically hurt by evil spirits.

23. The Attending also told the Respondent about the spiritual diagnosis.

24. The Respondent agreed that there could be a spiritual component to Patient A's presentation.

25. The Respondent informed the Attending that it was his opinion that the Attending should not continue to treat Patient A as the attending-of-the-day in the outpatient clinic.

26. The Attending told the Fellow and the Respondent that he was taking himself off of Patient A's case because the Attending believed that Patient A's symptoms and conditions were not psychiatric in nature.

27. The Respondent complimented the Attending for his courage in coming forward to him about his beliefs concerning Patient A and the spiritual diagnosis.

28. The Respondent told the Attending and the Fellow that it was interesting and unusual that both he, the Fellow, and the Attending agreed there could be a spiritual component to Patient A's diagnosis. The Respondent believed that not all of Children's Hospital's psychiatrists would entertain the belief that Patient A could be suffering from a spiritual diagnosis.

29. The Respondent agreed to coordinate a spiritual consultation on Patient A's behalf and on behalf of the outpatient treatment team from a Christian chaplain at Children's Hospital.

30. The Respondent was aware that the Attending was going to consult with his church about Patient A's spiritual issues and that Patient A might attend the Attendings' church.

31. The Attending eventually took Patient A to his church.

32. The Respondent articulated a plan that involved getting guidance from a Christian chaplain at Children's Hospital.

33. The Respondent never sought permission from Patient A's parents before seeking the spiritual consultation from the Christian chaplain.

34. The Respondent and the Fellow understood that the Fellow would continue to treat Patient A for her psychiatric conditions under the Respondent's supervision once Patient A was discharged from the inpatient unit.

35. The Respondent, who was a member of the outpatient team and did not attend inpatient team meetings, did not tell Patient A's inpatient team about the spiritual diagnosis or the Respondent's plan for spiritual consultation. The Respondent did not ensure that the Chaplain or any member of the treatment team told Patient A's mother about the spiritual diagnosis or the Respondent's plan to seek consultation with the hospital Chaplain.

36. The Respondent did not tell the Psychiatrist-In-Chief about the spiritual diagnosis or the Respondent's plan to seek consultation with the Christian chaplain.

37. There is no documentation of the spiritual diagnosis or the plan to seek spiritual consultation in the Children's Hospital records.

38. After the discussion involving the Respondent, the Attending, and the Fellow, the Attending participated in a meeting with the inpatient team and announced that he was taking himself off Patient A's case.

The Respondent's Knowledge of Boundary Issues

39. After Patient A was discharged from the inpatient unit, the Respondent learned that the Attending had paid Patient A multiple visits while Patient A was hospitalized.

40. The Attending's actions constituted potential boundary violations.

Patient A's Post-Hospitalization Treatment

41. After Patient A was discharged from Children's Hospital, the Fellow saw Patient A in Children's Hospital outpatient clinic on March 15, 2012 and March 27, 2012.

42. The Respondent continued to meet with the Fellow about Patient A and to sign the Fellow's treatment notes.

43. On February 25, 2012, after Patient A's discharge from the inpatient unit, the Respondent met with a Children's Hospital Christian chaplain and discussed Patient A's history and diagnosis as relayed by the Attending. The Respondent put the chaplain in touch with the Attending and the Fellow.

44. On February 25, 2012, the Attending told the Respondent that he spoke with a second psychiatric fellow whose father was a priest.

45. On February 25, 2012, when responding to the Attending's email, the Respondent wrote that the Attending's plan sounded good and that they should keep all of their options open.

46. The Respondent's plan was based, in part, on the spiritual diagnosis.

47. The Respondent's religious belief system allowed him to entertain the spiritual diagnosis and the spiritual plan for consultation with the Children's Hospital's Christian chaplain.

48. By developing and implementing his plan, the Respondent utilized his own religious belief rather than diagnostic concepts and therapeutic practice; however, he continued to supervise the Fellow's psychiatric and therapeutic treatment of Patient A in the outpatient clinic.

49. The Respondent failed to properly supervise the Fellow, when he developed and implemented his plan based in part on the spiritual diagnosis.

50. The Respondent failed to properly supervise the Fellow, when he initiated the spiritual consultation and arranged for the meeting between the Attending, the Fellow, and the chaplain.

51. 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."

The Respondent's Obligations to Report Suspected Child Abuse

52. At some point in March 2012, the Attending informed the Fellow that Patient A alleged that her mother had thrown her down a flight of stairs and had tried to asphyxiate her. The Fellow told the Respondent about the allegations of abuse that the Attending had relayed to her.

53. The Respondent told the Fellow to speak with Hospital Legal Counsel about what the Attending had told her.

54. The Respondent called the Attending to tell him that he was a mandated reporter as he had been the recipient of the allegations first hand.

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

56. The Respondent never told the Fellow to report to the Department of Children and Families and never followed up with the Fellow about going to Legal.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, ninth par. (b) and 243 CMR 1.03(5)(a)2, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician committed an offense against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder. More specifically:

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 of Children and Families orally and, within 48 hours, shall file a written report with the Department of Children and Families detailing the suspected abuse or neglect . . . ."

A. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.
Board Chair

Date: May 8, 2013

SENT CERTIFIED MAIL 5/8/13 (mg)