

STATE OF VERMONT
VERMONT OFFICE OF THE SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

Choc 7/17/04
RECEIVED ON
JUL 17 2004
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IN RE: DEBORAH ALICEN

DOCKET NO. PS 03-0900

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER
OF THE REVIEWING OFFICER

Appellant, Deborah Alicen, appeals to the reviewing officer from the July 9, 2000 decision of the Board of Psychological Examiners.

The Order appealed from dismissed Count I of the Specification of Charges, "Failure to Establish Goals and Boundaries for Note Taking." In addition it dismissed renumbered Count II, "Despondant's Dual Relationship as Expert Witness and Treating Therapist" and that portion of Count IV alleging a violation of 26 V.S.A. 3016(1). The dismissal of those portions of Specifications of Charges is not presented upon appeal and those decisions have become final.

The appeal is directed at the two counts of Specification of Charges which the Board concluded the State had proved by a preponderance of the evidence. They are renumbered Count III ("Inadequate Record Keeping"), which alleged 6 different specific violations, and renumbered Count IV ("Failure to Provide Records Upon Request"). For reasons as stated, *infra*, the Reviewing Officer has affirmed Count IV and has reversed and remanded Count III.

I. ISSUES INVOLVING COUNT IV, "FAILURE TO PROVIDE RECORDS UPON REQUEST."

The reviewing officer did read the entire transcript of this matter held before the Board and has analyzed the admitted exhibits. Based upon a reading of the transcript, evidence admitted, and the Board's decision, the following Findings are hereby made:

FINDINGS

1. Pertaining to this issue, the Board found that Deborah Alicen is a psychologist licensed by and subject to the regulatory authority of the Board. Dr. Alicen has been licensed since 1989.

2. The Complainant E E came to respondent with a significant psychological history. The Board felt that a recitation of that history was not necessary and, therefore, will not be repeated here either.

3. Ms. E had experienced a difficult relationship with her previous treatment provider. (Ann Unangst) Part of the presenting problem when she first saw Dr. Alicen involved the previous providers' records, especially treatment notes which Ms. E felt caused her harm. Evidently, the relationship with the previous provider left Ms. Edwards vulnerable.

4. During the course of Ms. E ' legal proceedings against her prior treatment provider, she requested that Dr. Alicen provide her entire records to her attorney. Dr. Alicen complied with this request.

5. In November 2000, D E requested by letter that Dr. Alicen make copies of her records available to her. On January 31, 2001 Ms. Edwards by letter asked Dr. Alicen for a portion of her clinical records, specifically documents relating to her treatment by

her former provider. In November, 2001, Ms. E by letter requested all records "you have created pertaining to my treatment," all records and diagnostic information submitted to Blue Cross to obtain payment for treatment, and any notes or records before, "I was insured by Blue Cross."

6. On January 22, 2002 Ms. E, through the Office of Health Care Ombudsman, made a final request for records. Dr. Alicen did not provide the records to either Ms. E or to the Ombudsman. The Ombudsman was Ms. E's representative for purposes of acquiring records.

7. Dr. Alicen testified that she had already provided records to Ms. E's attorney. In the Board's Opinion and Order, it stated that "Dr. Alicen provided no credible justification for not providing the records." As stated by the Board:

"That Dr. Alicen had provided the records to Ms. E's attorney in the past does not provide an excuse to deny Ms. E's request for records."

Page 4 Board's Decision.

8. After reading the entire transcript, the following facts as taken from the transcript relating to this issue are as follows:

9. Trinkia Kerr testified at the hearing. At the time of the hearing she was an attorney for Vermont Legal Aid and the project dealing with Health Care Ombudsman.

10. The Ombudsman office was established by the Vermont Legislature. The mandate of that office is to help Vermonters with problems with their health insurance or with health care. It is a statewide project. (T.93)

11. The Office of Ombudsman helps people with complaints regarding healthcare providers. (T.93)

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12. In January 2002 the Office of Ombudsman wrote a letter to Dr. Alicen requesting a copy of her records regarding D E . (T.97)

13. Admitted State's Exhibit 6 illustrates that D E authorized the Office of Ombudsman to get information from Dr. Alicen. (T.100)

14. As shown by State's Exhibit 8, as admitted, by fax Dr. Alicen refused to release the records. It was her feeling that she had no obligation to provide the records to E or to the Office of Ombudsman. (T.101)

15. At a meeting with the Office of Ombudsman, Dr. Alicen stated her opinion that it was "risky for the client's health, risky for her own safety and risky for our safety," to give out the information sought. In addition, Dr. Alicen did not think she legally had to provide the records. (T.103)

16. When complaining about Ann Unangst's decision to release records, it was the opinion of Dr. Alicen that Ms. Unangst should have asked the Licensing Board or the Vermont Society for advice. Ironically, in her own case, Dr. Alicen never asked advice from the Licensing Board as to whether or not she should release records to the Office of Ombudsman or to the client. (T.126-127)

17. Significantly, relating to this issue, the respondent had the following to say:

"Q. And why did you make the decision not to provide copies?

A. My decision not to provide her a copy was not because I felt the contents of the records would be harmful to her. She already knew the content. She had seen the content. What I felt would – had the potential for harm was the reenactment of this whole traumatic scenario. I was – in my decision to not provide the records, I was seeking to prevent harm by preventing that repetition."

(T.239)

18. In essence, despite the desire of both the client and the Office of Ombudsman to gain access to the records, the respondent, in effect, played "King Solomon" in the decision not to release the client's records to either herself or to her representative.

19. In addition, the following colloquy took place at the hearing:

"Q. What individuals, if any, did you consult with on providing those records when this issue came up with the Ombudsman?

A. None.

Q. Did you – you didn't ask any society?

A. No. No.

Q. Any other therapists?

A. No."

(T.262)

CONCLUSIONS OF LAW RE: FAILURE TO PROVIDE RECORDS

The statute dealing with "Unprofessional Conduct" states as follows:

"(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action. Any one of the following items, or any combination of items, whether or not the conduct at issue was committed within or outside the state, shall constitute unprofessional conduct.

(8) Failing to make available promptly to a person using professional healthcare services, that person's representative, succeeding healthcare professionals or institutions upon written request and direction of the person using professional healthcare services, copies of that person's records in the possession or under the control of the licensed practitioner."

For over one year the client sought the records from respondent. Subsequently, the client's representative, the Office of Ombudsman, sought the records. Consistently, respondent refused to give over the records. This is an obvious violation of 3 V.S.A. § 129a(a)(8).

The reviewing officer will give deference to the Board in its decision that a statutory violation did take place. That determination is hereby AFFIRMED. See Bigelow v. The Department of Taxes, 163 VT 33, 35 (1994). Braun v. Board of Dental Examiners, 167 VT 110, 114 (1997); In Re: Professional Nurses Services, Inc., 164 VT 529 (1996).

II. COUNT III. "INADEQUATE RECORD KEEPING"

Findings of Fact.

1. The Board promulgated its Specification of Charges against Dr. Alicen on November 22, 2002 per its Deputy Attorney General, George C. Haegele, IV. Relating to the question of Inadequate Record Keeping were the following charges:

- a. On or about March 4, 1996, Dr. Alicen began treating the patient, D
E, for Post Traumatic Stress Disorder.
- b. By way of history, the respondent was simultaneously an expert witness for Ms. Edwards in a civil malpractice suit against Ms. E's prior therapist.
- c. Respondent continued treating Ms. E until June, 2000.
- d. Respondent, in treating the client, failed to properly note the substance of the therapy and/or sessions.
- e. Respondent, in treating the client, failed to properly note relevant discussions with other providers and/or legal parties.

f. Respondent failed to properly note that she was deposed regarding the client's civil case.

g. Since respondent knew that Ms. E was involved in a current legal proceeding, respondent should have maintained notes sufficient for such a forum;

h. Respondent failed to have a fee agreement maintained in the notes.

i. The above acts, omissions and/or circumstances taken alone, together, or in any other combination, constitute unprofessional conduct pursuant to, and also violate: 26 V.S.A. 3016(11)(Gross Malpractice).

2. The reviewing officer, after reading the transcript, has not found any evidence that respondent failed to properly note that she was deposed regarding the client's civil case. In fact, there was no evidence that she was deposed at all. Therefore, #16 of Count VI (Charges) was never established.

3. The reviewing officer has not found any finding from the Board addressing the "Failure to have a fee agreement" as stated in #18 of Count VI (Charges).

4. The Board did address in its findings #14, 15, and 17 of the charge allegations. They will be dealt with, infra.

5. The reviewing officer will not address or analyze any of the findings in Count III as enunciated by the Board which do not have to do with #14, 15 or 17 of the Charges, Count VI. Therefore, those findings are deemed to be irrelevant to the specific charges which the Board was mandated to deal with.

6. The Board found that the State had proved by preponderance of the evidence that Dr. Alicen committed gross malpractice by failing to properly keep financial and treatment records regarding Ms. E . That is troublesome to the reviewing officer because the subject

of financial records was never even mentioned in the charges as were first brought by the Deputy Attorney General as aforementioned.

7. It was prejudicial to the respondent to have the Board consider facts and make findings on subjects which were not duly noticed to the respondent. In other words, because of the doctrine of fundamental fairness, the respondent was prejudiced by the discussion of any topics which were not noticed in the aforementioned charges.

8. Mary Wilmuth testified at the hearing for the State. She is a licensed psychologist in the State of Vermont.

9. At the hearing, Counsel for Dr. Alicen objected to Ms. Wilmuth testifying because she had been a member of the investigative team. The hearing officer allowed the testimony to go forward.

10. In speaking about the sufficiency of the notes taken Ms. Wilmuth stated as follows:

"Q. Now, from March of '96 until July of '98, are you able to, from your review of the records, determine what the therapy was focusing on?

A. The, the two pages of notes that go from – this patient was picked up in '96 and the notes start in 7-98 and 8-99. My understanding was there was at least one other session after the 8-99 date. And, clearly, there is no note about that. These notes – I have no way of knowing when these notes were written, and, and – but I would – given, given the debate in the profession about what constitutes sort of minimal amount of notes, session-per-session, I would say that these come close to meeting that standard. They may be far more minimal than many people would use, but I think as a minimal notes, they essentially do. I think the problem is..."

11. As stated in her testimony, Ms. Wilmuth narrated that she was on the first investigative team which concluded that the Alicen matter should not go to the Board for unprofessional conduct. (T.182)

12. Regarding rules and statutes in effect in March 1996, when Dr. Alicen first became involved with client E , the following colloquy took place between counsel for Dr. Alicen and Ms. Wilmuth:

“Q. Let’s talk about the specific Rules, and I want to talk about, first off, March 1996. Can you point to a specific Rule in effect at that time that mandated keeping notes?

A. The APA Code of Conduct has always been a source of...

Q. I’m not talking about a source, I’m talking about a specific rule or statute...

A. No.

Q. ...That was – OK, there was none. Is there a specific rule or statute that was in effect in March of 1996 that required a fee agreement to be noted in the record?

A. There’s no specific rule or statute at that time.

Q. OK. Can you point to a specific rule or statute that required a decision about the absence of note taking to be noted at that time?

A. There was not a specific explicit rule or statute, no.”

T.192

13. At the hearing, Ms. Wilmuth also stated the following which had some significance to the reviewing officer:

“Q. OK. And do you think, given that absence of a rule specifically drafted requiring someone to keep records in 1996, that a psychologist who’s confronted with a client, who feels as though she’s been traumatized by a psychologist’s, another psychologist’s records, could make a clinical judgment that record keeping was not in this client’s best interests at that time?

A. Could or should?

Q. Could.

A. I mean, obviously, in this instant, the psychologist did.

Q. Correct.

A. So one clearly can...

Q. Dr. Wilmuth, my question is do you believe in this case Dr. Alicen's decision about note taking in the early phases of her work with D E , was the exercise of clinical judgment?

A. It was obviously a judgment.

Q. And do you believe that it was based upon Dr. Alicen's understanding of the client's problems and presentation?

A. Well, I certainly believe that it was based on Dr. Alicen's understanding of the problems, yes.

Q. OK. OK. And it was – and OK. And would it also be possible that the fact that the subsequent notes were, were as you said, somewhat minimal, that that could be, again, in keeping with Dr. Alicen's clinical judgment about the best way to handle therapy with this patient?

A. It clearly was her clinical judgment to do it that way."

T.200-201

14. Because of her past trauma concerning the notes produced by Ann Unangst, Ms. E did not wish for her new psychologist, Dr. Alicen, to take notes. Dr. Alicen testified at the hearing that she consulted with other professionals around this issue. Based on there being no legal requirement through her perception, Dr. Alicen agreed that she would forego the keeping of notes until such time as she would be comfortable with that (the client) and that they would work toward the time that she would be comfortable with the keeping of notes. (See T.221-222)

15. Per her testimony, Dr. Alicen stated that she "revisited the matter" of note taking a minimum of every three months. (T.222)

CONCLUSIONS OF LAW RE: INADEQUATE RECORD KEEPING

As can be seen by the Findings, supra, the Reviewing Officer has read the entire transcript, He has sited relevant portions of that transcript. Regarding the charges involving "Inadequate Record Keeping", there are certainly due process issues which are troublesome.

A license to practice a profession is a property right which cannot be taken from the licensee without Due Process of Law. In Re: Ruffalo, 390 U.S. 544, 550, 88 S.Ct. 1222 (1968). Also, See Brody v. Barash, 155 VT 103, 107 (1990). Those aforementioned cases do seem to dictate that a complaint seeking discipline against a professional license must state specifically the acts complained of in order to allow the licensee a fair chance for defense. It does seem unfair to make findings on matters that were not charged originally by the Attorney General. In its Conclusions of Law, for instance, the Board stated that Dr. Alicen had committed gross malpractice by failing to properly keep financial and treatment records regarding Ms. E. However, the question of financial records was never even mentioned in the original charges dated November 22, 2002.

It is clear that the Board did legitimately make findings on matters which were charged such as treatment records. However, as the transcript illustrates, the only "expert" testifying on the violation of standards for psychologists was Mary Wilmuth. She had been a member of the investigative team. To the reviewing officer, that does bring up questions regarding "fundamental fairness." How objective is a so-called expert witness when that witness was on the investigative team which brought the original charges in the first place? That is quite unusual, to say the least!

On page one of its decision, the Board stated that it would "use its own expertise independent of any proffered expert testimony in deciding this case." In other words, the Board deliberated using its own expertise.

It is important to note that the Board found "malpractice" regarding "inadequate record keeping." The State had the burden of producing an expert witness setting forth standards of skill and care and alleged departure of Dr. Alicen from those standards. Also, the State had to

show that the conduct was the proximate cause of the harm complained of. See Senesac v. Assoc. In Obstetrics and Gynecology, 141 VT 310, 313 (1982).

The State, in its Brief, emphasizes the case of Braun v. Board of Dental Examiners, 167 VT 110, 114 (1997). It stresses the “deference” which must be given to professional boards evaluating their own professionals. However, in the opinion of the Reviewing Officer, Braun does not state that a board can declare “malpractice” without expert testimony given at a hearing. The Board stated, in page one of its decision, that it had “used its own expertise independent of any proffered expert testimony in deciding this case.” That is problematic.

The following other State jurisdictions have come to the conclusion that the required professional standard of practice must be expert testimony on the record: Arthurs v. Board of Registration, 418 N.E.2nd 1236 (Mass. 1981) (A board of experts sitting in a quasi-judicial capacity cannot be silent witnesses as well as judges); Dailey v. North Carolina State Board of Dental Examiners, 309 S.E.2nd 219 (1983) (Board may not make its own judgment of the evidence); Rutledge v. Department of Registration and Education, 222 N.E.2nd 195 (Ill. App. 1966) (The finding of the committee must be based on evidence presented in the case – nothing can be treated as evidence which is not introduced as such).

Because the State has strongly argued that Braun should control, the Reviewing Officer spent some time in reviewing the contents of Braun. Without question, the Vermont Supreme Court had emphasized that a Board should be given deference in making its own decisions. However, when one looks at Braun more closely, one quickly sees that the Court has stated that the Supreme Court would affirm the Board’s findings as long as they are supported by substantial evidence, and its conclusions if rationally derived from the findings and based on a correct interpretation of the law. Id., at 114.

What is important to note about Braun, supra, is that the Supreme Court did review that record. Most importantly, the Court noted that the State did have its own expert at the hearing who testified to the malpractice of Dr. Braun. What did not happen is that the Board in Braun made its own decision without scrutinizing the testimony of an independent expert. Therefore, with all due respect, the Reviewing Officer reads the Braun case in mandating the same types of protection as was noted in the other brother states, supra.

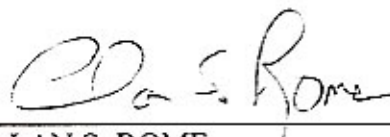
ORDER

The findings and conclusions of law pertaining to Count III "Inadequate Record Keeping" are hereby reversed and remanded to the Board of Psychological Examiners with directions to deliberate consistent with the dictates of this opinion.

Further Order on entire case:

Originally the Board had dismissed two counts and found two counts against Dr. Alicen. Subsequent to this Order, the count dealing with "Failure to Provide Records Upon Request" has been AFFIRMED. The count dealing with "Inadequate Record Keeping" has been REVERSED AND REMANDED. The Reviewing Officer is cognizant of the fact that the Board had suspended Dr. Alicen from practice for a period of 60 days beginning August 1, 2003. Therefore, it is the hope of the Reviewing Officer that the Board will deliberate as soon as possible to make a new Order in line with this present decision and order.

DATED at Montpelier, Vermont this 8th day of July, 2004.



ALAN S. ROME
Reviewing Officer

DATE OF ENTRY 7/15/04

RECEIVED ON
JUL 19 2004
PUTTER