Public

STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 15, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nessim Roumi, M.D.
2522 Ocean Avenue
Brooklyn, New York 11299

Nancy Strohmeyer, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Scott W. Pearl, Esq.
Platzer, Luca & Pearl
61 Broadway – Suite 1601
New York, New York 10006

NYS Department of Health
Bureau of Accounts Management
ESP-Corning Tower-Room 1717
Albany, New York 12237

RE: In the Matter of Nessim Roumi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-08) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of Nessim Roumi, M.D. (Respondent) A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	Administrative Review Board (ARB) Determination and Order No. 10-08 COPY

Before ARB Members D'Anna, Koenig, Wagle, Wilson and Milone
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Nancy Strohmeyer, Esq.
For the Respondent: Scott W. Pearl, Esq.

After a hearing below, a BPMC Committee determined that the Respondent practiced medicine with repeated negligence and incompetence and that the Respondent failed to maintain accurate records in treating and prescribing for five patients. The Committee voted to suspend the Respondent's license to practice medicine in New York State (License), to place the Respondent on probation, to order retraining and to fine the Respondent $30,000.00. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2010), the Petitioner asked the ARB to overturn the penalty the Committee imposed and to revoke the Respondent's License. After reviewing the hearing record and the parties' review submissions, the ARB votes 5-0 to revoke the Respondent's License.

Committee Determination on the Charges

The Committee conducted a hearing on charges that the Respondent violated New York Education Law (EL) §§ 6530(3), 6530(5) and 6530(32) (McKinney 2010) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with incompetence on more than one occasion, and,
- failing to maintain accurate patient records.

The charges related to the care that the Respondent provided to five persons (Patients A to E). The record refers to the Patients by initials to protect patient privacy. Following the hearing, the Committee rendered the Determination now on review.

The Committee found the Respondent's records illegible and useless without transcription. The Committee sustained the charges that the Respondent failed to maintain accurate records for each Patient A to E. The Respondent's review reply brief, at page 5, conceded that the Respondent's charting of his thought process was less than optimal and that the Respondent would benefit from remedial training in that regard. The Committee sustained the charges that the Respondent practiced with negligence and incompetence in treating all five Patients A to E. The Committee found that the Respondent failed to perform appropriate examinations and obtain appropriate histories for all five Patients and that the Respondent prescribed opioid medications inappropriately for all five Patients. The Committee found that the Respondent failed to treat an open wound on Patient A and failed to refer Patient A appropriately to consulting specialists. The Committee found that the Respondent sent Patient C for tests involving thyroid functions and that the Patient's tests revealed a normally functioning thyroid. Despite that result, the Respondent prescribed the synthetic thyroid hormone, synthroid, for Patient C. The Committee found that the Respondent failed to follow up on suspicions of a thyroid disorder with Patient E and failed to perform a physical examination that included palpating the Patient's thyroid. The Committee found that Patient B reported to the Respondent that the Patient lost a month's supply of the pain reliever Norco on the day after the Respondent wrote the prescription. The Respondent gave the Patient a new prescription without making an attempt to determine if the Patient was abusing drugs. The Committee found that the Respondent gave Patient B a prescription for one month's supply of pain relievers on each of six office visits over a ten week period in 2005 and the Respondent prescribed a four month supply of pain

relievers for Patient A over a five week period in 2005. The Committee concluded that the Respondent performed inadequate monitoring of pain medications for the Patients A and B.

The Petitioner presented two witnesses at the hearing, Louis Bass, D.O and Brendan Vallely. Dr. Bass testified as the Petitioner's medical expert and Mr. Vallely explained the computer evidence concerning the prescriptions the Respondent wrote for opioids. The Committee found both witnesses credible and persuasive. The Respondent did not testify and did not present any witnesses.

The Committee noted that no evidence at the hearing showed actual patient harm, but the panel saw a substantial risk for harm to patients from the negligent prescribing of opioids. The Committee voted to suspend the Respondent's License for six month, to fine the Respondent $30,000.00 and to place the Respondent on probation for one year, under the terms that appear at Appendix I to the Committee's Determination. The probation terms require practicing with a monitor and completing 50 hours in continuing medical education courses.

Review History and Issues

The Committee rendered their Determination on January 13, 2010. This proceeding commenced on January 25, 2010, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's reply brief. The record closed when the ARB received the reply brief on March 8, 2010.

The Petitioner alleges that the penalty the Committee imposed provides insufficient protection to protect the public and the Petitioner asks that the ARB revoke the Respondent's License. The Petitioner argued that the Respondent's misconduct implicated the very core of his practice and demonstrated that, despite years of experience, the Respondent was unable to manage the care for patients with common internal medical complaints. The Petitioner contended that the penalty from the Committee's Determination contained no component to address the

most dangerous deficiency in the Respondent's practice, the prescribing of controlled substances. The Petitioner described both the continuing education and the probation as inadequate. The Petitioner argued that the continuing education penalty failed to specify course work to address the Respondent's failures and assumed the Respondent possesses a capacity for re-education and self-correction. The Petitioner called the probation insufficient because the one-year term would fail to ensure that the Respondent has corrected his deficiencies and could practice safely. The Petitioner argued further that the Committee made the assumption that the Respondent's deficiencies are susceptible to total and rapid remediation. The Petitioner questioned whether any penalty could fill the gaps in the Respondent's knowledge and break a lifetime of bad habits.

In reply, the Respondent described the Petitioner's request for revocation as vindictive. The Respondent noted that the case involved no actual patient harm and no questions of integrity or moral fitness. The Respondent argued that a skilled and seasoned hearing committee found a need for rehabilitation and fashioned a sanction to allow for oversight that would assure patient safety.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on

the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with negligence and incompetence on more than one occasion and that the Respondent failed to maintain accurate patient records. The testimony

the Committee found credible from Dr. Bass and Mr. Vallely provided preponderant evidence to support the Committee's findings and conclusions. The Respondent failed to testify himself or to produce other witnesses to challenge the Petitioner's witnesses. The ARB overturns the penalty the Committee imposed and votes 5-0 to revoke the Respondent's License.

The Committee imposed an actual suspension on the Respondent's License and a large fine and the Committee placed the Respondent on probation for one year with a practice monitor and a requirement to complete 50 hours continuing medical education. The ARB doubts that the actual time on suspension and the fine will provide a sufficient sanction to make the Respondent realize the need to change his practice and to take greater care in prescribing controlled substances. The Committee found that the Respondent practiced with incompetence in treating all five patients at issue. Practicing with incompetence shows that a physician lacks the skill or knowledge necessary to practice the profession safely, Matter of Dhabuwala v. SBPC, 225 A.D.2d 609, 651 N.Y.S.2d 249 (3rd Dept. 1996). Continuing education or retraining can improve skill and/or knowledge, if a respondent realizes the need for the retraining and is willing to learn. The Respondent failed to testify at the hearing, so no basis exists from the hearing record to conclude that the Respondent realizes his deficiencies and is willing to work to correct them. The Respondent's brief conceded a need to improve record keeping, but the brief made no mention concerning the greatest problem with the Respondent's practice, the prescribing. The penalty provides for the retraining to occur after the suspension, during the probation, but the probation terms set no requirements for the retraining other than the number of hours. The Respondent could comply with the retraining requirement by taking 50 hours of courses in any area of medicine. The ARB agrees with the Petitioner that the retraining and one year on probation are unlikely to correct gaps in knowledge and bad practices that developed over a long career.

The Respondent placed several patients at risk repeatedly, over a period from 2001 to 2005. The ARB sees nothing in this record to lead to the assumption that the Respondent has corrected the problems in his practice since the time he treated Patients A to E. The Respondent prescribed controlled substances inappropriately to all the Patients, he failed to record adequate histories and/or adequate examinations, he failed to make needed referrals and he failed to address patient conditions such as the open wound in Patient A and the possible thyroid disorder for Patient E. The Committee found that the Respondent's prescribing pattern places patients at risk and nothing in this record shows a realization or inclination by the Respondent concerning the need to correct that prescribing pattern. The ARB concludes that the only way we can assure patient safety in this case is to remove the Respondent from practice.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB overturns the Committee's Determination to suspend the Respondent's License, to place the Respondent on probation, to require the Respondent to complete retraining and to fine the Respondent $30,000.00.
3. The ARB votes 5-0 to revoke the Respondent's License.

Peter S. Koenig, Sr.
Datta G. Wagle, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Nessim Roumi, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Roumi.

Dated: 14 June, 2010

REDACTED

Linda Prescott Wilson

In the Matter of Nessim Roumi, M.D.

Peter S. Koenig, Sr., an ARB Member concurs in the Determination and Order in the Matter of Dr. Roumi.

Dated: 06/10/2010, 2010

REDACTED

Peter S. Koenig, Sr.

In the Matter of Nessim Roumi, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Roumi.

Dated: June 10, 2010

REDACTED

Datta G. Wagle, M.D.

In the Matter of Nessim Roumi, M.D.

Richard D. Milone, an ARB Member concurs in the Determination and Order in the Matter of Dr. Roumi.

Dated: June 9, 2010

REDACTED

Richard D. Milone, M.D.

In the Matter of Nessim Roumi, M.D.

John A. D'Anna, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Roumi.

Dated: JUNE 15, 2010

REDACTED

John A. D'Anna, M.D.