These charges are only allegations which may be contested by the licensee in an Administrative hearing.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF SUDIPT SURESHCHANDRA DESHMUKH, M.D.	NOTICE OF HEARING

TO: SUDIPT SURESHCHANDRA DESHMUKH, M.D.
c/o Dennis Gruttadaro, Esq.
Brown, Gruttadaro & Prato, PLLC
Hale House
19 Prince Street
Rochester, NY 14607
(attorney for Respondent)

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 20, 2018 at 10:00 a.m., at the Offices of the New York State Department of Health, Central New York Regional Office, 217 South Salina Street, Syracuse, New York, 13202, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses

and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATE Albany, New York
October 16, 2018

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:

David Quist
Associate Attorney
N.Y.S. Department of Health
Division of Legal Affairs
Bureau of Professional Medical Conduct
Room 2512, Corning Tower, ESP
Albany, New York 12237
(518) 473-4282

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF SUDIPT SURESHCHANDRA DESHMUKH, M.D.	STATEMENT OF CHARGES

SUDIPT SURESHCHANDRA DESHMUKH, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 2, 1994, by the issuance of license number 196756 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (all patients are identified in the Appendix), a 33-year-old female when Respondent began treating her, from on or about April 11, 2008 to on or about January 27, 2015. Respondent provided care for conditions including but not limited to fibromyalgia, attention deficit disorder, chronic pain and depression. Respondent's care and treatment of Patient A failed to meet accepted standards of medical practice, in that:

1. Respondent, on one or more occasions, from November 2010 through September 2011, failed to adequately examine and/or document such examination of Patient A.
2. Respondent, on one or more occasions, from November 2010 through April 2014, prescribed pain medications including but not limited to oxycodone-acetaminophen and/or fentanyl to Patient A without adequate medical indication, and/or without documenting adequate medical indication.

3. Respondent, on one or more occasions from October 2012 through June 2014, failed to adequately address, and/or failed to document having addressed, evidence of possible substance abuse and/or diversion by Patient A.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.

B. Respondent provided medical care to Patient B, a 21-year-old female when Respondent began treating her, from on or about June 4, 2008 to on or about August 6, 2015. Respondent provided care for conditions including but not limited to chronic pain, anxiety and migraine headaches. Respondent's care and treatment of Patient B failed to meet accepted standards of medical practice, in that:

1. Respondent, on one or more occasions from November 2012 through August 2014, prescribed medications including but not limited to fentanyl, butalbital, and/or oxycodone to Patient B without adequate medical indication, and/or without documenting adequate medical indication.
2. Respondent, on one or more occasions, beginning in May 2012, prescribed butalbital to Patient B without adequately informing her of the risk of rebound headache as a side-effect, and/or without documenting that he so informed the patient of this risk.
3. Respondent, on one or more occasions, including but not limited to in January 2013, prescribed fentanyl to Patient B without adequately informing Patient B of the risk of sedation and/or addiction, and/or without documenting that he so informed the patient of these risks.
4. Respondent, despite having been informed in or about September 2013 and May 2014 of concerns raised by other providers regarding her medications as prescribed by Respondent, failed to adequately respond to such concerns by taking measures including but not limited to adequately counseling the patient regarding the risks of continued use and/or dosage of the prescribed medications, adequately modifying his prescribing of such medications to

Patient B, and/or to adequately pursuing other modalities of treatment for Patient B, and/or to document that such measures were taken.

5. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient B.

C. Respondent provided medical care to Patient C, a 48-year-old male when Respondent began treating him, from on or about April 7, 2006 to on or about December 24, 2014. Respondent provided care for conditions including but not limited to chronic pain, and abdominal and other pains. Respondent's care and treatment of Patient C failed to meet accepted standards of medical practice, in that:

1. Respondent, on one or more occasions, from October 2008 through April 2014, prescribed and/or administered various combinations of medications to Patient C, including but not limited to oxycodone, alprazolam, pregabalin, carisoprodol, ketorolac and/or aspirin without adequate medical indication, and/or without documenting adequate medical indication.
2. Respondent administered ketorolac to Patient C, in or about August 2014, without adequately informing Patient C of the associated risks, and/or failed to document that such information had been provided to Patient C. The risks of which Patient C should have been informed include but are not limited to the increased risk of stroke or heart attack associated with the use of ketorolac and meloxicam, in conjunction with the use of aspirin.
3. Respondent, including but not limited to in January 2013, prescribed oxycodone, pregabalin, and and/or carisoprodol to Patient C in various combinations, without informing Patient C of the risk of synergistic sedative effects of the simultaneous use of such medications, and/or without documenting that such information had been provided to Patient C.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C.

D. Respondent provided medical care to Patient D, a 25-year-old male with a history of drug abuse when Respondent began treating him, from on or about January 19, 2009 to on or about February 6, 2014 or March 11, 2014. Respondent provided care for conditions including but not limited to chronic back pain, anxiety, depression, drug dependency and withdrawal, and insomnia. Respondent's care and treatment of Patient D failed to meet accepted standards of medical practice, in that:

1. Respondent, on one or more occasions, including but not limited to in May 2012, prescribed medications, including but not limited to benzodiazepines and/or sleep-aid medications, to Patient D without adequate medical indication and/or despite knowing Patient D was taking methadone and muscle relaxants, despite the risk of potentially synergistic effects of such medications and/or despite Patient D's history of drug abuse; and/or failed to document adequate medical indication.
2. Respondent, on one or more occasions, including but not limited to in May 2012, failed to adequately inform Patient D of the risk of synergistic sedative effects of the simultaneous use of opioids, benzodiazepines, muscle relaxants and sleep medications, in various combinations, and/or to adequately document that such information had been provided to Patient D.
3. Respondent, on one or more occasions, from April 2013 through February 2014, prescribed medications including but not limited to butalbital, tramadol, and/or Lunesta to Patient D without adequate medical indication, and/or failed to document adequate medical indication.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. The facts in Paragraphs A and A.1, A and A2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, and/or D and D.4.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. The facts in Paragraphs A and A.1, A and A2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, and/or D and D.4

THIRD THROUGH FIFTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on an occasion as alleged in the facts of the following:

3. The facts in Paragraphs B and B.4.
4. The facts in Paragraphs C and C.3.
5. The facts in Paragraphs D and D.1 and/or D and D.2.

SIXTH THROUGH EIGHTH SPECIFICATION
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. The facts in Paragraphs B and B.4.
7. The facts in Paragraphs C and C.3.
8. The facts in Paragraphs D and D.1 and/or D and D.2.

NINTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

9. The facts in Paragraphs A. and A.1, A and A.2, A. and A.3, A. and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, and/or D and D.4.

DATE: October 16, 2018
Albany, New York

MICHAEL A. HISER, ESQ.
Deputy Counsel
Bureau of Professional Medical Conduct