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

January 13, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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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 Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

NESSIM ROUMI, M.D.

DETERMINATION

AND

ORDER

BPMC #10-08

COPY

A Notice of Hearing and Statement of Charges were served on NESSIM ROUMI, M.D. on May 12, 2009. Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on August 13, September 25, and October 6, 2009 at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **Frank E. Iaquinta, M.D.**., CHAIR, **Ralph J. Lucariello, M.D.**, and **James J. Ducey**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **David A. Lenihan, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Petitioner appeared by **Thomas Conway, Esq.**, General Counsel, by **Nancy Strohmeyer, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with counsel, **Scott W. Pearl, Esq.** Evidence was received, including witnesses who were sworn or affirmed, and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	May 12, 2009
Answer Filed:	June 11, 2009
Pre-Hearing Conference:	June 2, 2009
Hearing Dates:	August 13, 2009 September 25, 2009 October 6, 2009
Witnesses for Petitioner:	Louis Bass, D.O. Brendan Vallely
Witnesses for Respondent:	None
Deliberations Date:	December 1, 2009

STATEMENT OF THE CASE

Petitioner has charged Respondent, Dr. Nessim Roumi, with three specifications of committing professional misconduct as defined in N.Y. Education Law § 6530 (3), § 6530 (5), and § 6530 (32.)

The charges relate to the care and treatment rendered by Dr. Roumi to five patients. The first specification alleges negligence on more than one occasion in violation of N.Y. Education Law § 6530 (3). The second specification alleges incompetence on more than one occasion in violation of N.Y. Education Law § 6530 (5). The third specification alleges failure to maintain proper records for his patients in violation of N.Y. Education Law § 6530 (32). Respondent denied all three allegations.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix II.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to transcript page numbers or exhibits, denoted by the prefixes "T." or "Ex." These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous.

1. Respondent, Nessim Roumi, M.D., was licensed to practice medicine in New York State on or about January 28, 1988 by the issuance of license number 173545 (Petitioner's Ex. 2).

Patient A

2. Patient A was a 40 year-old male at the start of treatment with Respondent on June 17, 2004 (T. 16; Petitioner's Exhibits 3, 3a, p. 1).

3. At his first visit with Respondent, Patient A complained of paresthesia, numbness in his toes, generalized pain and that he could not feel pain in a gunshot wound. Patient A also reported that he felt dizziness and lightheadedness, and that he had "never felt this way before." Respondent remarked in his notes that Patient A had suffered a stab wound to the posterior chest and a gunshot wound to the right leg (T. 16, 20-21; Petitioner's Exhibits 3, 3a, p. 1).

4. Respondent's physical examination of Patient A did not include a neurological examination or pain testing. A reasonably prudent physician would have included these examinations in his evaluation of this patient at this visit (T. 16-17; Petitioner's Exhibits 3, 3a, p. 1).

5. Respondent's history for Patient A did not include information concerning Patient A's stab and gunshot wounds including whether he had been hospitalized, and if so, where and for how long. Respondent also failed to include information concerning what specific treatment was rendered or whether Patient A had surgical and neurological consultations. In addition, Respondent failed to ask Patient A what medications he was taking at the outset of treatment (T. 20-21; Petitioner's Exhibits 3, 3a, p. 1).

6. A reasonably prudent physician would have obtained all of this information because it would be important to know all of the presenting circumstances before prescribing any other medications to a patient (T. 21).

7. Respondent failed to obtain a family health history for Patient A. A reasonably prudent physician would have obtained such information from a patient in order to determine if there were any conditions that could be genetically transferred to the patient or if there were any other issues impacting on the chief complaint (T. 20-21; Petitioner's Exhibits 3, 3a, p. 1).

8. At the conclusion of his note for Patient A's initial visit, Respondent noted that he prescribed Vicodin ES, "qid, p.r.n." (four times a day, as needed) Vicodin is an opioid analgesic, which Respondent prescribed to be taken four times a day as needed. There was no other plan of care noted for Patient A (T. 22-23; Petitioner's Exhibits 3, 3a, p. 1).

9. A reasonably prudent physician would have sought to obtain the records from Patient A's prior treating physicians including records of any hospital care Patient A may have received for his stab and gunshot wounds. Based upon Patient's complaints, his plan of care should have included a neurological evaluation and imaging studies of the brain and lumbar spine (T. 23-25; Petitioner's Exhibits 3, 3a, p. 1).

10. The deficits in Respondent's physical examination, history and plan of care for this patient visit on June 17, 2004 are deviations from the minimum accepted standard of medical care (T. 24-25).

11. On July 1, 2004, Patient A presented to Respondent's office complaining of back pain, discomfort and stiffness. Respondent noted that he was "status post shooting" and that there was a "deep ulcer" in Patient A's left axilla as well as lacerations on his chest. Respondent noted that Patient A's leg elevation was decreased due to pain and that his calf was tender (T. 26-27; Petitioner's Exhibits 3, 3a, p. 1).

12. Respondent's physical examination at this visit did not include neurological reflexes, a pain scale to describe the back discomfort or an indication of diminished pulses. Respondent also failed to assess and note Patient A's degrees of elevation when performing a straight leg-raising test. A reasonably prudent physician would have included these elements in a physical examination at this visit (T. 26; Petitioner's Exhibits 3, 3a, p. 1).

13. Respondent's failure to include these elements in a physical examination at this visit was a deviation from minimum accepted standards of medical care (T. 26).

14. At the July 1, 2004 visit, a reasonably prudent physician would have assessed the condition of the ulcer and noted whether it was draining. If it was draining, the character of the material draining from the wound should have been noted. This assessment should also have included determining whether the ulcer was infected and whether a culture needed to be taken. Respondent failed to make these assessments (T. 26-27).

15. Respondent's failure to adequately assess the ulcer he noted was a deviation from minimum accepted standards of medical care (T. 27).

16. In his note of the July 1, 2004 visit, Respondent noted a clinical impression of "lumbar spondylosis radiculopathy and stab wounds" for Patient A. No additional comment is entered in the record about these stab wounds. Lumbar spondylosis describes degenerative or arthritic changes in the lumbar spine. It is typically diagnosed by an x-ray of the lumbar spine. There was no x-ray of Patient's lumbar spine at this visit. A physician should also palpate the lumbar spine and perform range of motion testing to determine whether the patient has nerve injuries. Radicular pain is pain caused by pressure or

pinching of a nerve root that emanates from the spinal cord. When assessing a clinical impression of radiculopathy, a physician would note which nerve root was involved (T. 28; Petitioner's Exhibits 3, 3a, p. 1).

17. The physical examination and assessment Respondent performed at this visit does not support a diagnosis of lumbar spondylosis. This failure to adequately assess the patient's condition is a deviation from minimum accepted standards of medical care (T. 28).

18. Respondent did not indicate a plan of care for Patient A in his July 1, 2004 office visit note. A reasonably prudent physician would have included an x-ray of the lumbar spine in this patient's plan of care. Additionally, the hospital records for this patient should have been obtained, reviewed and any omissions from the record, such as missing radiological studies or examinations, should have been ordered. Respondent's failure to include these elements in a plan of care for Patient A at this visit was a deviation from minimum accepted standards of medical care (T. 30-31).

19. On July 1, 2004, Respondent prescribed Percocet to Patient A. Percocet is an opioid analgesic, but is not the same drug that was prescribed at the previous visit. There is no indication in the note for this visit as to why this medication was prescribed or why there was a change in prescription from the last visit. A reasonably prudent physician would have assessed and recorded the degree of Patient A's pain to determine whether an opioid analgesic was necessary to manage this patient's pain (T. 31-33; Petitioner's Exhibits 3, 3a, p. 1).

20. The failure to assess the efficacy and document the changes in Patient A's medication was a deviation from minimum accepted standards of medical care (T. 32-33, 220).

21. On July 15, 2004, Patient A presented to Respondent's office complaining of fatigue, tremors, anxiety and reporting that he was "afraid to die." Respondent also noted an "open wound" (T. 33; Petitioner's Exhibits 3, 3a, p. 1).

22. Respondent failed to obtain a more detailed description of Patient A's emotional complaints, and did not assess whether the fatigue complained of was related to his emotional complaints or medical ones. Respondent additionally failed to assess Patient A's complaints of tremors (T. 31-33; Petitioner's Exhibits 3, 3a, p. 1).

23. Respondent's failure to include these assessments in his examination was a deviation from minimum accepted standards of medical care (T. 36).

24. Throughout Respondent's treatment of Patient A, he diagnosed Patient A with lumbar spondylosis. An x-ray taken on August 2, 2004, indicated no degenerative changes in Patient A's lumbar spine and ruled out this diagnosis. Given the results of this imaging study, a reasonably prudent physician would have explored a different cause for Patient A's pain (T. 37-38; Petitioner's Exhibits 3, p. 13, 3a, p. 1).

25. In the entirety of Respondent's medical record for Patient A, there is no indication that Patient A was evaluated for a herniated disc or other nerve root compression that could have caused his back pain and explained Respondent's diagnosis of lumbar radiculopathy. During the course of treatment there is no indication that Respondent performed an adequate neurological examination, muscle testing or sensory testing to

evaluate Patient A's complaints of numbness, tingling and pain in his back and legs (T. 38-39; Petitioner's Exhibits 3, 3a).

26. A reasonably prudent physician would have performed these evaluations. Respondent's failure to do so constitutes a deviation from minimum accepted standards of medical care (T. 39).

27. In treating Patient A's pain, a reasonably prudent physician would have initially prescribed non-steroidal anti-inflammatory medication, muscle relaxants and employed physical therapy modalities. A reasonably prudent physician would determine what the patient's initial response to this regimen was, and adjust it accordingly (T. 40).

28. There is no indication in the medical record for Patient A that Respondent pursued these treatments for Patient A. His failure to do so was a deviation from minimum accepted standards of medical care (T. 40).

29. On April 19, 2005, Respondent prescribed 90 OxyContin 80 milligram pills to be taken three times a day for Patient A. OxyContin is an opioid analgesic. As prescribed, this is a month's supply of OxyContin (T. 42; Petitioner's Exhibits 3, 3a, p. 4, Petitioner's Ex. 8).

30. On April 26, 2005, one week after Patient A's previous visit, Respondent prescribed a month's supply of Norco 325, which is an opioid analgesic similar to OxyContin. In his record for Patient A, Respondent failed to indicate why he chose to prescribe Norco 325 the number of day's supply he dispensed. A reasonably prudent physician would have documented this change (T. 42, 220; Petitioner's Exhibits 3, 3a, p. 4, Petitioner's Ex. 8).

31. On May 18, 2005, Respondent prescribed a 30-day supply of OxyContin for Patient A. There is no indication why Respondent changed Patient A's pain medication in the note for this office visit. (T. 43; Petitioner's Exhibits 3, 3a, p. 4, Petitioner's Ex. 8).

32. On May 25, 2005, Respondent prescribed a month's supply of Norco 325 for Patient A. There is no indication why Respondent changed Patient A's pain medication in the note for this office visit this (T. 42; Petitioner's Exhibits 3, 3a, p. 4, Petitioner's Ex. 8).

33. A reasonably prudent physician would not prescribe two month's supply of opioid analgesics in a one-week period of time without determining whether the patient was abusing the medication or there was a change in clinical status that required a change in pain management. This assessment would include discussing with the patient his response to medications and his need for extra medications (T. 45-46, 236-38).

34. Respondent's failure to make these assessments, monitor Patient A's use of pain medication and document the changes in prescribing were deviations from minimum accepted standards of medical care (T. 43-44, 220, 236-38; Petitioner's Exhibits 3, 3a, p. 4).

35. The purpose of medical records is to document the doctor-patient relationship as it occurs, and to preserve a record of the treatment for subsequent treating physicians or consultants. Respondent's handwritten records for this Patient A were illegible. Respondent's transcriptions of his handwritten records failed to document adequate histories or physical examinations. Respondent's medical record for Patient A does not adequately document his prescribing for this patient. Respondent's medical records for Patient A do not adequately reflect the care and treatment rendered to Patient A. This

failure was a deviation from minimum accepted standards of medical care (T. 51-52; Petitioner's Exhibits 3, 3a).

Patient B

36. Patient B was a 28 year-old male at the outset of treatment on December 13, 2004. He presented to Respondent's office complaining of "back problems." Respondent noted that the pain was worse on the right side and that Patient B had no "radicular syndrome" (T. 58; Petitioner's Exhibits 4, 4a, p. 1)..

37. Respondent's physical examination of Patient B at this visit did not include examination of reflexes, pulses, an assessment of degrees of elevation on the left side of Patient B's body, and grading of the patient's paraspinal stiffness and pain. Failure to include these elements in a physical examination for this patient was a deviation from minimum accepted standards of medical care this (T. 59-60; Petitioner's Exhibits 4, 4a, p. 1).

38. Respondent's medical history of Patient B did not include information concerning what, if any, medications Patient B was taking. Failure to include this information in Patient B's history was a deviation from minimum accepted standards of medical care (T. 61-62; Petitioner's Exhibits 4, 4a, p. 1).

39. In his note for Patient B's visit on December 13, 2004, Respondent noted an impression and plan of lumbar spondylosis and "rule out radiculopathy." Respondent

failed to order an x-ray on this date to confirm his impression of lumbar spondylosis. Radiculopathy is diagnosed clinically by making an abnormal finding on a neurological examination such as straight leg raising or by testing that indicates altered sensory or motor nerve functioning. There is no indication in Respondent's medical record for Patient B that he conducted the assessment necessary to rule out radiculopathy. Respondent's failure to perform these assessments was a deviation from minimum accepted standards of medical care (T.62-64; Petitioner's Exhibits 4, 4a, p. 1).

40. On February 16, 2005, Patient B presented to Respondent's office a second time. He complained of tiredness and fatigue, low back pain and radiating pain (T.62-64; Petitioner's Exhibits 4, 4a, p. 1).

41. At this visit, a reasonably prudent physician would have noted how many degrees of leg elevation were present in his physical examination and whether this pain was bilateral. A reasonably prudent physician would have noted whether the symptom of back pain was better or worse and whether stiffness on palpation had changed or not. Respondent's failure to include these elements in a physical examination at this visit was a deviation from minimum accepted standards of medical care (T. 66-67).

42. Respondent noted an impression of lumbar spondylosis on February 16, 2005. Respondent had not obtained an x-ray of Patient B's lumbar spine, and the physical examination on this date does not support a diagnosis of lumbar spondylosis. Respondent's plan of care for this patient at this time should have included plans for an x-ray or MRI and a more complete assessment of the patient's radicular symptoms (T.66-68; Petitioner's Exhibits 4, 4a, p. 1).

43. Failure to include these elements in a plan of care for Patient B at this visit was a deviation from minimum accepted standards of medical care (T. 68-69).

44. On February 16, 2005, Respondent prescribed a 30-day supply of Norco 10/325, an opioid analgesic, to Patient B. On February 17, 2005, Respondent noted that Patient B "lost" his prescription for the opioid, and Respondent wrote another prescription for a month's supply of Norco 10/325. (T. 71-72; Petitioner's Exhibits 4, 4a, p. 1).

45. A reasonably prudent physician would have discussed the lost prescription with Patient B in an effort to discern whether the patient was abusing drugs. There is no indication in the notes for February 17, 2005 or the following visit on March 10, 2005, that Respondent had such a discussion with Patient B. Respondent's failure to do so was a deviation from minimum accepted standards of medical care (T. 72-73; Petitioner's Exhibits 4, 4a, p. 1).

46. At each of Patient B's six office visits between March 10, 2005 and June 1, 2005, Respondent prescribed a 30-day supply of an opioid analgesic to Patient B. The various pain medications included Percocet, Vicodin and Norco. A reasonably prudent physician would have assessed Patient B's various pain complaints to determine what the severity of his pain was and what clinical changes had occurred that caused Patient B to need ever escalating amounts of pain medication. This assessment would include speaking with the patient concerning his use of the medication. In addition, he or she would have would have documented the reasons for changing the medications prescribed at these visits. Respondent failed to conduct these assessments. His failure to do so and to monitor

Patient B's use of pain medication were deviations from minimum accepted standards of medical care (T.72-78, 220, 236-38; Petitioner's Exhibits 4, 4a, p. 1).

47. Respondent's handwritten records for Patient B were illegible. Respondent's transcriptions of his handwritten records failed to document adequate histories or physical examinations, and do not adequately document his prescribing for this patient. Respondent's medical records for Patient B did not adequately reflect the care and treatment rendered to Patient B. This failure was a deviation from minimum accepted standards of medical care (T. 78-79; Petitioner's Exhibits 4, 4a).

Patient C

48. Patient C was a 27 year-old female at the outset of treatment on July 10, 2001. At this visit, Respondent noted that Patient C was "status post injury, cervical spine," that her thyroid was hyperactive, she suffered from night sweats, palpitations and chest pain (T. 86-87; Petitioner's Exhibits 5, 5a, p.1).

49. Given this presentation, a reasonably prudent physician would have included a range of motion testing for Patient C's cervical spine and palpation of the spine in an examination. Testing of the reflexes and motor sensory responses of the upper extremities and assessment of paraspinal tenderness or limitation also should have been performed. A reasonably prudent physician would have examined patient C's thyroid gland for masses or enlargement. In addition, a reasonably prudent physician would have

obtained more information from Patient C concerning the character or quality of her chest pain and diaphoresis or sweats, and a description of her palpitations (T. 89-90; Petitioner's Exhibits 5, 5a, p.1).

50. Respondent failed to include these elements in his physical examination of Patient C at this visit, and his failure to do so was a deviation from minimum accepted standards of medical care (T. 90; Petitioner's Exhibits 5, 5a, p.1).

51. A reasonably prudent physician would have included information concerning Patient C's cervical spine injury in his or her history. Specifically, a reasonably prudent physician would have asked when the incident occurred, what if any subsequent care occurred and who the treating physicians were. A reasonably prudent physician also would have obtained a prior cardiac history from this patient, history of any previous thyroid condition, menstrual history and history of weight change (T. 90-91, 251-52).

52. Respondent failed to elicit any of these elements for Patient C's history, and his failure to do so was a deviation from minimum accepted standards of medical care. (T. 91, 251-52; Petitioner's Exhibits 5, 5a, p.1).

53. In his note for Patient C's first visit, Respondent notes an impression and plan of hypertension, obesity, "palpitation secondary thyroid," and to rule out hyperthyroidism and obtain blood tests while "consider[ing]" a thyroid sonogram. Thyroid conditions are typically diagnosed in patients who have a change in weight, sweats, tachycardia, rapid heartbeat, a positive history of thyroid problems, and are taking medications that might affect the thyroid (T. 92-93; Petitioner's Exhibits 5, 5a, p.1).

54. On July 10, 2001, Patient C had blood tests performed, which included several tests of thyroid function. Those tests included a T-3 Uptake Test, a T4 Total Test, a T-7 (Free Thyroxin Index Test) and a TSH (thyroid-stimulating hormone) test. Patient C's blood tests indicated generally normal thyroid functioning. Her TSH level was slightly elevated and this suggests an under active thyroid (T. 93-94; Petitioner's Exhibits 5, p. 4, 5a, p.1).

55. In his note for Patient C's August 7, 2001 office visit, Respondent noted that Patient C had hyperthyroidism and he prescribed Synthroid, a synthetic thyroid hormone replacement. Patient C's blood tests did not support a diagnosis of hyperthyroidism. Patient C's TSH level was 4.08 µIU/ml, (milli-International Units per liter) just slightly above the upper limit range of 4.00 µIU/ml. A reasonably prudent physician would not have made this plan of care for Patient C because there was no documentation of a hyperactive thyroid condition (T. 94-96, 251-52; Petitioner's Exhibits 5, 5a, p.1).

56. Respondent next saw Patient C on May 4, 2003. In his note for this visit, Respondent does not indicate whether there has been follow up on Patient C's thyroid complaints and her symptoms of palpitations and chest pain by him or any other physician. Respondent does not elicit or note Patient C's condition or history since the prior visit nearly two years earlier. Respondent notes that Patient C "wants to have baby" and missed her period, but does not note when her last menstrual period was. Respondent's failure to obtain this history was a deviation from minimum accepted standards of medical care (T. 97-98; Petitioner's Exhibits 5, 5a, p.1).

57. In his note for the May 4, 2003 visit, Respondent notes an impression of hypothyroidism, fatigue and obesity (T. 98; Petitioner's Exhibits 5, 5a, p.1).

58. On May 8, 2003, Respondent again notes an impression of hypothyroidism and included a question of whether "change due to pregnancy" (T. 98; Petitioner's Exhibits 5, 5a, p.1).

59. Patient C's blood tests on May 8, 2003, include thyroid testing. The results indicated normal thyroid function values that are inconsistent with a diagnosis of hypothyroidism. The laboratory report also includes a positive pregnancy test (T. 98-100, 118; Petitioner's Exhibits 5, pp. 7-8; 5a, p.1).

60. Patient C next came to Respondent's office on August 26, 2004. She complained of low back pain radiating to the thigh, discomfort standing and bending and a large weight gain. Respondent noted that Patient C exhibited lumbar paraspinal stiffness and that her leg elevation was decreased secondary to pain. Respondent noted an impression of lumbar spondylosis and lumbar radiculopathy at this visit, and prescribed a 30-day supply of Percocet (T. 101-102; Petitioner's Exhibits 5, 5a, p.1).

61. In his physical examination of Patient C, Respondent failed to completely examine her leg elevation to assess pain level. Respondent failed to note the degree, quality, and radiation of Patient C's pain and what factors alleviated or exacerbated it. Respondent also failed to discern and note any focal neurological abnormalities upon examination. These deficiencies were deviations from minimum accepted standards of medical care (T. 102-03; Petitioner's Exhibits 5, 5a, p.1).

62. In his note of Patient C's August 26, 2004 office visit, Respondent failed to document information concerning the progress and outcome of Patient C's pregnancy and the status of her prior thyroid complaints. Respondent's failure to include these elements in Patient

C's medical history at this visit was a deviation from minimum accepted standards of medical care (T. 103-104; Petitioner's Exhibits 5, 5a, p.1).

63. A diagnosis of lumbar spondylosis is typically made by taking an x-ray of the lumbar spine. A physician should also palpate the lumbar spine and perform range of motion testing to determine whether the patient has nerve injuries. When assessing a clinical impression of radiculopathy, a reasonably prudent physician would assess the patient's motor strength and sensory change to light, touch, pain, vibration and her reflexes (T. 28, 103-04; Petitioner's Exhibits 5, 5a, p. 1).

64. The physical examination and assessment Respondent performed at this visit did not support a diagnosis of lumbar spondylosis or lumbar radiculopathy. This failure to adequately assess the patient's condition was a deviation from minimum accepted standards of medical care (T. 28, 103-04).

65. Respondent's plan of care for Patient C at this visit included a prescription for Percocet. A reasonably prudent physician would have included an x-ray of her lumbar spine in a plan of care for Patient C. Respondent's failure to do so was a deviation from minimum accepted standards of medical care (T. 106-07; Petitioner's Exhibits 5, 5a, p. 1).

66. In order to determine a treatment plan for Patient C, a reasonably prudent physician would have assessed and documented the degree of the patient's pain. Respondent failed to assess and document Patient C's pain levels, and this was a deviation from minimum accepted standards of medical care (T. 107-08; Petitioner's Exhibits 5, 5a, p. 1).

67. In visits on November 29, 2004, December 29, 2004 and July 22, 2005, Patient C consistently reported lower back pain and difficulties in walking, standing and bending. A

reasonably prudent physician would have performed a thorough orthopedic evaluation and assessed the patient's somatic function through muscle testing and sensory and motor testing. An x-ray should have been ordered. Respondent's failure to include these elements in his assessment of Patient C were deviations from minimum accepted standards of medical care (T. 107-08; Petitioner's Exhibits 5, 5a, p. 1).

68. In visits on November 29, 2004, December 29, 2004 and July 22, 2005, Respondent prescribed opioid analgesics to Patient C. A reasonably prudent physician would have first prescribed non-steroidal anti-inflammatory drugs or other non-opioid analgesics for Patient C's pain complaints. Respondent's failure to attempt a trial of non-opioid medication in this patient was a deviation from minimum accepted standards of medical care (T. 1113-16; Petitioner's Exhibits 5, 5a, p. 1).

69. Respondent's handwritten records for this Patient C were illegible. Respondent's transcriptions of his handwritten records failed to document adequate histories or physical examinations, and do not adequately document his prescribing for this patient. Respondent's medical records for Patient C did not adequately reflect the care and treatment rendered to Patient C. This failure was a deviation from minimum accepted standards of medical care (T. 116; Petitioner's Exhibits 5, 5a).

Patient D

70. Patient D was a 21-year–old female at the outset of treatment with Respondent on January 14, 2002. Her chief complaint at that visit was inability to move her right side.

Respondent's physical examination did not include an assessment of Patient C's reflexes, motor strength and ability to walk without pain (T. 126-28; Petitioner's Exhibits 6, 6a, p.1).

71. A reasonably prudent physician would have included these assessments in a physical examination of Patient D at this visit. Respondent's failure to do so was a deviation from minimum accepted standards of medical care (T. 127-28).

72. In his note for Patient D's initial visit, Respondent notes that she had surgery for spinal scoliosis which involved insertion of a metal rod and that she had surgery for a meniscal tear in her knee. A reasonably prudent physician would have obtained a detailed history of these surgeries including information regarding when and where they took place, what the long-term effects of the operations were and whether Patient D's medical condition changed as a result. A reasonably prudent physician would also want to know details of Patient D's underlying condition including its onset and therapies and medications used. Respondent did not obtain this history. His failure to do so was a deviation from minimum accepted standards of medical care (T. 128-30, 132-33; Petitioner's Exhibits 6, 6a, p.1).

73. Respondent noted an impression of lumbar radiculopathy and scoliosis for Patient D. Based upon what is documented for this patient, a reasonably prudent physician would have included in a plan of care obtaining the records of Patient D's surgeries and prior imaging studies and consultation records. There is no indication in Patient D's medical record that Respondent ever did this. Respondent's failure to do so was a deviation from minimum accepted standards of medical care (T. 130-32; Petitioner's Exhibits 6, 6a, p.1).

74. On January 24, 2002, Patient D presented to Respondent's office complaining of lower back pain and tenderness and discomfort walking, standing and sitting for long periods of time. A reasonably prudent physician would have conducted a pain assessment on Patient D. This would have included rating Patient D's pain and noting the quality of the pain and its effects on activities of daily living. Additionally, a reasonably prudent physician would have asked what medication and physical therapy modalities Patient D was using to cope with the pain. Respondent failed to do this, and this failure was a deviation from minimum accepted standards of medical care (T. 133-35; Petitioner's Exhibits 6, 6a, p.1).

75. Respondent noted lumbar radiculopathy as an impression at this visit. To diagnose lumbar radiculopathy, a reasonably prudent physician would order an EMG or electromyography. Respondent failed to order this test for Patient D, and his failure to do so was a deviation from minimum accepted standards of medical care (T. 135-37; Petitioner's Exhibits 6, 6a, p.1).

76. On February 10, 2004, Patient D presented to Respondent's office complaining of knee pain, low back pain and a dotted rash on her abdomen. It had been over a year since Respondent had last seen Patient D. At this visit, a reasonably prudent physician would have included a complete neurological and orthopedic examination consisting of motor and sensory testing, and reflexes and pulses. Additionally, a reasonably prudent physician would have included a description of the rash in his notes. This description should have included the location and quality of the rash. Respondent did not conduct these examinations or make these notations. His failure to do so was a deviation from minimum accepted standards of medical care (T. 135-37; Petitioner's Exhibits 6, 6a, p.1).

77. At Patient D's visit on February 10, 2004, a reasonably prudent physician would have included information concerning the nature and genesis of her knee pain and abdominal rash. Information to update prior complaints should have been obtained, and any changes in the patient's medical history in the previous year should have been noted. Respondent's failure to obtain and document this history was a deviation from minimum accepted standards of medical care (T. 140-41; Petitioner's Exhibits 6, 6a, p.1).

78. At each of Patient D's office visits on January 14, 2002, February 12, 2002, October 29, 2002, July 19, 2005, and August 22, 2005, Respondent prescribed various pain medications to Patient D including Percocet, Vicodin and OxyContin. A reasonably prudent physician would have assessed Patient D's various pain complaints to determine what the severity of her pain was and what if any clinical changes had occurred prior to changing Patient D's medication. In addition, a prudent physician would have would have documented the reasons for changing the medications prescribed at these visits. Respondent failed to conduct and document these assessments, and his failure to do so was a deviation from minimum accepted standards of medical care (T. 143-145, 220; Petitioner's Exhibits 6, 6a, p. 1-2, 4).

79. Respondent's handwritten records for this Patient D were illegible. Respondent's transcriptions of his handwritten records failed to document adequate histories or physical examinations, and do not adequately document his prescribing for this patient. Respondent's medical records for Patient D did not adequately reflect the care and treatment rendered to Patient D. This failure was a deviation from minimum accepted standards of medical care (T.150; Petitioner's Exhibits 6, 6a).

Patient E

80. Patient E was a 27 year-old female at the outset of treatment on August 16, 2004. Respondent noted a complaint of lower back pain. Patient E, according to the record, had been in a motor vehicle accident five months earlier and herniated a disc and had taken Vicodin. Patient E reported that she had been taking Paxil and Xanax but that she discontinued Paxil two months earlier because it "didn't do a thing" (T. 159-61; Petitioner's Exhibits 7, 7a, p. 1).

81. A reasonably prudent physician would have elicited information from Patient E concerning the onset of back pain, gynecological, surgical, and medical history, and family history. A reasonably prudent physician would have asked Patient E for details of her use of Paxil, Xanax and Vicodin. Respondent failed to do this and his failure was a deviation from minimum accepted standards of medical care. (T. 160-65; Petitioner's Exhibits 7, 7a, p. 1).

82. Respondent's physical examination of Patient E at this visit did not include examination of reflexes, motor sensation, or an assessment of the patient's paraspinal stiffness and pain. Failure to include these elements in a physical examination for this patient was a deviation from minimum accepted standards of medical care (T. 163; Petitioner's Exhibits 7, 7a, p. 1).

83. At this visit, Respondent prescribed Vicodin ES, Xanax, an anxiolytic, and Zyrtec, a non-sedating antihistamine. A reasonably prudent physician would document the

reasons he was prescribing medications. Respondent failed to document his reasons for prescribing these medications, and this was a deviation from minimum accepted standards of medical care. (T. 170-72; Petitioner's Exhibits 7, 7a, p. 1).

84. In an undated note, Respondent documented "questionable hypothyroidism" as an impression for Patient E. Respondent put in her medical record the words "obtain blood tests". (T. 166; Petitioner's Exhibits 7, 7a, p. 1).

85. A reasonably prudent physician who suspects a patient may have a thyroid disorder would order blood tests for that patient and perform a physical examination that includes palpation of the thyroid. Additionally, a reasonably prudent physician would question such a patient about any symptoms of thyroid disease which she may have such as changes in weight or menstrual periods, and chills or diaphoresis. Respondent failed to order diagnostic blood work for this patient. In addition, he failed to perform an examination assessing her thyroid function and he did not question her concerning possible symptoms of thyroid disease. Respondent's failure to do so was a deviation from minimum accepted standards of medical care. (T. 165-66; Petitioner's Exhibits 7, 7a, p. 1).

86. Respondent's handwritten records for this Patient E were illegible. Respondent's transcriptions of his handwritten records failed to document adequate histories or physical examinations. Respondent's medical records for Patient E did not adequately reflect the care and treatment rendered to Patient E. This failure was a deviation from minimum accepted standards of medical care (T. 175-76; Petitioner's Exhibits 7, 7a, p. 1).

CONCLUSIONS OF LAW

Respondent is charged with five specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct, which constitute professional misconduct, but does not provide definitions of the various types of misconduct. The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. New York State Bd. for Professional Medical Conduct, 195 A.D.2d 86, 88-89 (3rd Dept. 1993). Proof that a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances is sufficient to sustain a finding of "negligence" in a medical disciplinary proceeding. It is untenable to require a finding that a *specific* patient was placed at risk before permitting respondents to act. The purpose of such a proceeding is to protect the welfare of the general public who deal with State-licensed practitioners. *(see also,* Matter of Morfesis v. Sobol, 172 A.D. 2d 897) That purpose is not promoted by injecting into the proceeding an element of foreseeable risk of injury to a *specific* patient, inasmuch as the public at large deserves protection from the risks attendant to substandard medical care. Such care, if left unchecked, will "assuredly result" in injury. Matter of Morfesis v. Sobol, *supra* at 899.

For the remaining specifications of professional misconduct, the Hearing Committee

interpreted the statutory language in light of the usual and commonly understood meaning of the language.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

Based on the above noted Findings of Fact, the panel concluded, unanimously, that Factual Allegations A 1 b and c, A2, A3, A4, A5, and A6, B 1, b, c, and d, B 2, B 3, and B 4, C 1 to 5, D 1 to 4 and E 1 to 5, as set forth in the Statement of Charges (Appendix 2), were proven by a clear preponderance of the evidence. The panel concluded, also unanimously, that Factual Allegations A 1 a and B 1 a, as set forth in the Statement of Charges (Appendix 2), were **not** proven by a clear preponderance of the evidence. The Hearing Committee, therefore, by unanimous vote, SUSTAINED factual allegations A 1 b and c, A2, A3, A4, A5 , and A6, B 1, b, c, and d, B 2, B 3, and B 4, C 1 to 5, D 1 to 4 and E 1 to 5, and did **not sustain** the Factual Allegations A 1 a and B 1 a.

The rationale for the Hearing Committee's conclusions is set forth in the Discussion below.

VOTE OF THE HEARING COMMITTEE

FIRST SPECIFICATION

Negligence on more than one occasion

Respondents are charged with committing professional misconduct as defined in

N.Y. Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged.

Vote: SUSTAINED (3-0)

SECOND SPECIFICATION

Incompetence on more than one occasion

Respondents are charged with committing professional misconduct as defined in N.Y. Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged.

Vote: SUSTAINED (3- 0)

THIRD SPECIFICATION

Failure to maintain records

Respondents are charged with committing professional misconduct as defined in N.Y. Education Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of that patient.

Vote: SUSTAINED (3-0)

DISCUSSION

The Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the three (3) hearing days, the Department's Proposed Findings of Fact, Conclusions of Law, and Sanction as well as the Respondent's Proposed Findings of Fact and Conclusions of Law. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Allegations and Charges set forth in the Statement of Charges. (Appendix II)

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a preponderance of the evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegations presented are more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim.

3. The specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the charges by a preponderance of the evidence and, as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and to base its inference on what it accepts as the truth.

4. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee understands that, as the trier of fact, they may accept so much of a witness's testimony as is deemed true and disregard what they find and determine to be false. In the alternative, the Hearing Committee may determine that if the testimony of a witness on a material issue is willfully false and given with an intention to deceive, then the Hearing Committee may disregard all of the witness's testimony.

5. The Hearing Committee employed ordinary English usage and vernacular for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented two witnesses and the panel found both to be credible and persuasive: Louis Bass, D.O. and Brendan Vallely. Dr . Bass was called as an expert witness by the Department to testify to the Respondent's medical practice and Mr. Valley was called to explain the computer evidence of the Respondent's opioid prescription writing.

The Respondent chose not to testify. Notwithstanding the failure of the Respondent to testify, the panel carefully reviewed all the testimony and examined all the factual

allegations, point by point, to determine if they were established by a preponderance of the evidence. The panel found the testimony of the Department's main witness, Dr. Bass, to be credible and persuasive and the panel sustained all of the factual allegations except those alleging the failure to refer to non-pharmacological solutions. For those allegations, the panel found that the Department had not established its case by a preponderance of the evidence.

As for the remainder of the allegations, the panel reviewed the entire record and transcript of the hearings and made its determinations on the specific allegations, point by point, for each patient as follows:

Patient A

A. 1. a. The panel found that the failure to attempt non-pharmacological modes of pain management was not sustained in the record. The testimony at T. 204 shows that Dr. Hirschfeld did not indicate in his report that some non-pharmacological modality would be helpful. The panel did not agree with the conclusion of Dr. Bass, at T. 40, that the failure to attempt non-pharmacological modes of pain management was a deviation from minimally accepted standards of care.

A.1. b. The panel found that the Respondent prescribed pain medication inappropriately and therefore did sustain this allegation. The panel looked to T. 46 and saw no clear indication as to why this medication, OxyContin, or its dosages were changed. At T. 43, the testimony shows that the Respondent's recordkeeping does not indicate how many day's supply of opioids was being prescribed and the panel agreed that this was a deviation from the minimum accepted standards.

A.1. c. The panel found inadequate monitoring of Patient A's pain medication and that this was shown on T. 45 when a two month supply of opioid analgesics was given within a one-week period of time and therefore sustained this allegation.

A. 2. The panel found that there was no evidence in the record of appropriate referrals of Patient A to consulting specialists and so they sustained this allegation.

A. 3. The panel found that Respondent failed to treat an open wound and looked to T. 27 and saw that an assessment of an ulceration should have been made and saw that there was no indication that Respondent made the proper assessment of the ulcer. The panel agreed that this was a deviation from minimum accepted standards of medical care.

A .4. and A.5. The panel found that Respondent failed to obtain an adequate medical history of patient A or do an adequate physical examination and looked to T. 20 and found that there was no indication of whether the patient was hospitalized and whether other physicians were involved or whether any specific treatment was rendered or whether or not there was any surgical treatment or consultations. This inadequate history more than sustained this allegation. In addition, T 26 shows that necessary elements were missing in the physical exam.

A. 6. The Medical records in evidence for Patient A, Exhibit 3 were, beyond any doubt, not legible as the witness attests at T. 15. The documents themselves plainly show this and thus the panel sustained the allegation of inadequate recordkeeping.

Patient B

B. 1. a. As with Patient A, the panel found that the failure to attempt non-pharmacological modes of pain management was not sustained in the record. T. 204 shows that Dr. Hirschfeld did not indicate in his report that some non-pharmacological modality would be helpful. The panel again did not agree with the conclusion of Dr. Bass at T. 40 that the failure to attempt non-pharmacological modes of pain management was a deviation from minimally accepted standards of care.

B. 1. b. As for the charge of prescribing pain medication inappropriately, the panel looked to the testimony of Dr. Bass (T. 107) and found that the record had no description of the degree of pain and thus the level of prescribing was deemed inappropriate and a deviation from minimum accepted standards of medical care.

B.1. c. Similarly, the record shows no monitoring of the pain medication.

B.1. d. Again, since the record shows no pain scale reported (T. 108) there was no way to evaluate the degree of pain, something the panel deemed important when opioids are being prescribed.

B.2. The panel found that there was a failure to perform an adequate physical examination for Patient B and saw at (T. 59 – 60) that the examination that was done did not include reflexes, pulses, and a grading of the paraspinal stiffness or any grading of the patient's pain. This was seen as a deviation from minimum accepted standards of care.

B.3. The panel found an inadequate medical history for Patient B (T. 61) in that there is nothing in the medical record about the medications this patient was taking before coming to the Respondent.

B.4. The Medical records in evidence for Patient B, Exhibit 4 were, beyond any doubt, not legible as the witness attests at T. 78 –79. The documents themselves plainly show this and thus the panel sustained the allegation of inadequate record keeping.

Patient C

C. 1. a. The panel found a failure to obtain appropriate diagnostic testing at T. 102 where no focal neurological abnormalities were noted in the examination and an absence of any reference to prior thyroid complaints. It was also noted that the failure to include x-rays in the plan of care for this patient was a deviation from the minimum standard of care.

C .1. b. The panel found inappropriate pain medication prescribing at T. 108 where it was noted that there was no indication from the record of the level of pain.

C. 2. a. The panel found that the testimony, at T. 94, shows that the lab testing does not support a diagnosis of hyperthyroidism and, in fact, the lab results are showing a finding of results in the upper normal range.

C . 2. b. The record shows that the Respondent prescribed Synthroid for this patient and this is something a reasonably prudent physician would not have done because there was no documentation of a hypothyroid condition.

C . 3. The panel found a failure to perform an adequate physical examination for Patient C, in that there was a complaint of diaphoresis (T. 89) and no specific examination or notation as to whether there were associated chills or sweats. The examination did not explore the causes of the diaphoresis and this was a deviation from accepted standards of care.

C .4. The panel found that there was no indication in the record of the level of Patient C's level of pain (T. 108) and this is something a reasonably prudent physician would have included in his documentation of the pain and this, the panel agreed, was a deviation from the minimum accepted standards of medical care.

C. 5. The Medical records in evidence for Patient C, Exhibit 5, were, beyond any doubt, not legible as the witness attests at T. 116. The documents themselves plainly show this and thus the panel sustained the allegation of inadequate record keeping.

Patient D

D. 1. a. This patient presented with lumbar radiculopathy and the record does not indicate that appropriate testing was done to confirm this (T. 136), thus the panel found that the Respondent failed to obtain appropriate diagnostic testing such as electromyographies or x-rays.

D. 1. b. As for the inappropriate pain medication prescribing, the panel found that the prescription for Vicodin was changed and there was no indication of the reason given in the record. A reasonably prudent physician would have done so, and so there was a finding of deviation from the minimum accepted standards of care.

D. 2. The physical examination of Patient D was found inadequate, at T. 128, in that no range of motion for the knee was reflected in the record. This failure was a deviation from the minimum accepted standards of care.

D. 3. As for Patient D's medical history, the record is showing, at T. 130, that this patient had spinal surgery. The Respondent made no inquiry about this surgery as to how the patient was doing at present and whether or not she was still under that surgeon's care. It

was noted that the failure to make these inquiries was a deviation from the minimum accepted standards of care.

D. 4. The Medical records in evidence for Patient D, Exhibit 6, were, beyond any doubt, not legible as the witness attests at, T. 150. The documents themselves plainly show this and thus the panel sustained the allegation of inadequate record keeping.

Patient E

E. 1. a. This patient presented with a thyroid disorder and there is no indication in the testimony that appropriate blood tests were ever done to evaluate this condition (T. 165), thus the panel found that there was a failure to obtain appropriate diagnostic testing.

E. 1. b. The panel determined from the testimony (T. 172) and the record that the Vicodin prescription was not appropriate because the record was not clear why Vicodin was still being prescribed five months after the car accident, that had, apparently, occasioned the original prescription. This was a deviation from the minimum accepted standards of care.

E .2. The record, at T. 165, shows no blood tests for questionable hypothyroidism. The failure to properly assess this condition was found, by the panel, to be a deviation from the minimum accepted standards of care.

E. 3. As for a proper physical examination, T. 166 shows that a proper physical examination would have assessed hypothyroidism and that this was not done. The panel found this failure to be a deviation from the minimum accepted standards of care.

E. 4. As for medical history, the testimony, at T. 172, shows that there is no clear record of the medications that this patient was taking and why they were prescribed. This failure, the panel agreed, was a deviation from the minimum accepted standards of care.

E. 5. The Medical records in evidence for Patient E, Exhibit 7, were, beyond any doubt, not legible as the witness attests at T. 175. The documents themselves plainly show this and thus the panel sustained the allegation of inadequate record keeping.

The panel carefully reviewed all the testimony and documentation received into evidence in this case and concluded that the charges for the three specifications should be sustained. The Department established, by a preponderance of the evidence, that there was negligence and incompetence on more than one occasion along with a clear failure to maintain proper records for all five of these patients.

The panel is fully aware of the fact that the Department's case did not present evidence of actual harm done to patients. Nevertheless, the panel saw a substantial risk to patients in the negligent prescribing of opioids and is aware that significant harm could have resulted from the practices evident in this case. The failure to take proper patient histories and make a record of pain levels coupled with the failure to do appropriate tests, all establish the finding of negligence and incompetence on several occasions. The charge of failing to keep proper records is established on every page of the Respondent's medical records in evidence. All of this Respondent's notes are illegible and useless without transcription. The panel was, therefore, unanimous in sustaining all three specifications in this case.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, after due deliberation, unanimously determined that all three of the specifications raised against Respondent were sustained. The panel noted that the allegations of failing to attempt non-pharmacological modes of pain management (A.1. a and B. 1. a) were not sustained. Since all the other allegations were sustained the panel found that all three specifications were sustained.

The Committee has a responsibility to protect the patients and people of the State of New York. The issue before this Committee is to impose a penalty that offers the best protection to the people of the State. The panel weighed all the evidence and testimony and appreciated the seriousness of the offenses charged

It should also be noted that the panel concluded that the factual allegations about attempts not being made to try non-pharmacological modes of pain management, A 1 a and B 1 a, were **not** proven by a clear preponderance of the evidence. In conclusion, the Hearing Committee, by unanimous vote, SUSTAINED factual allegations A.1.b. and c., A.2., A.3., A.4., A.5., and A.6., B. 1., b., c., and d., B. 2., B. 3., and B. 4., C. 1. to 5., D. 1. to 4. and E. 1. to 5., and did **not sustain** the Factual Allegations A.1. a. and B.1. a.

The Department requested that a sanction of revocation be imposed in this case. The panel considered this and the full range of penalties available and determined that the people and patients of the State would be protected by a Suspension of the Respondent's license to practice medicine for six months coupled with a $30,000 fine and one year of probation with terms as set forth in Appendix I attached hereto.

ORDER

IT IS HEREBY ORDERED THAT:

1. The First, Second, and Third Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

2. The Respondent's license to practice medicine is **Suspended** for a period of Six Months.

3. Subsequent to the above Suspension, the Respondent is placed on a term of **PROBATION** of one year. The terms of the probation are attached hereto as Appendix 1 and are incorporated into this Order.

4. A fine of $10,000.00 for each specification of misconduct, for a total of $30,000.00 is imposed on the Respondent. The fine is payable in full within 30 days of the effective date of this Order. Payment must be submitted to the New York State Department of Health, Bureau of Accounts Management, Empire State Plaza, Corning Tower, Room 1717, Albany, New York 12237. Failure to pay the fine on time will subject the Respondent to all provisions of law relating to debt collection by New York State, including imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits and licenses (Tax Law Section 171[27], State Finance Law Section 18, CPLR Section 5001, Executive Law Section 32).

5. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Pelham Manor, New York

Jan. 12, 2010

Redacted Signature

Frank E. Iaquinta, M.D.,

Ralph J. Lucariello, M.D.

James J. Ducey

TO:

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

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New York State Dept. of Health
Bureau of Accts. Management
Corning Tower, Room 1717
Empire State Plaza
Albany, NY 12237

APPENDIX I

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 1218O-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order

4. Respondent shall maintain legible and complete medical records, which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed, at any time, by the Director of OPMC. This review may include, but shall not be limited to,

a review of all financial records, office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. During the period of probation, the Respondent shall take 50 hours of CME courses, approved by of the Director of OPMC. The cost of this education shall be the responsibility of the Respondent.

8. During the year of Probation, Respondent shall practice medicine only when a practice monitor shall be present in his office. The practice monitor shall be on-site during office hours, unless determined otherwise by the Director of OPMC. The practice monitor shall be proposed by the Respondent and subject to the written approval of the Director of OPMC. The practice monitor shall not be a family member or personal friend, or be in a professional relationship, which could pose a conflict with supervision responsibilities. The cost of this monitoring shall be the responsibility of the Respondent.

9. Respondent shall ensure that the practice monitor is familiar with the Order and terms of probation, and be willing to report to OPMC. Respondent shall ensure that the practice monitor is in a position to regularly observe and assess Respondent's medical practice, including his record keeping and patient record, with a view to insuring that be legible and clear. Respondent shall cause the practice monitor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC

10. Respondent shall authorize the practice monitor to have access to patient records and to submit quarterly written reports to the Director of OPMC, regarding Respondent's practice, including, but not limited to the clarity and legibility of patient records. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, and other such on-duty conduct as the practice monitor deems appropriate to report

APPENDIX 2

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

IN THE MATTER

OF

NESSIM ROUMI, M.D.

NOTICE

OF

HEARING

TO: Nessim Roumi, M.D.
2522 Ocean Avenue
Brooklyn, New York 11229

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 June 24, 2009, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 10007, 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 Redacted Signature

EXHIBIT

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, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, 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.

DATED: New York, New York
May 1, 2009

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Nancy Strohmeyer
Assistant Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007
(212) 417-4109

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

IN THE MATTER

OF

NESSIM ROUMI, M.D.

STATEMENT

OF

CHARGES

NESSIM ROUMI, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 28, 1988, by the issuance of license number 173545 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between June 17, 2004 and September 1, 2005, Respondent treated Patient A, who was a 40 year-old male at the onset of treatment. Respondent treated Patient A at his office in Brooklyn, New York. Respondent's care of Patient A deviated from minimum accepted standards of care in that:

1. Respondent failed to assess and treat adequately Patient A's complaints of pain, including but not limited to:
   a. Failing to attempt non-pharmacological modes of pain management;
   b. Inappropriately prescribing pain medication;
   c. Inadequately monitoring Patient A's use of pain medication.
2. Respondent failed to appropriately refer Patient A to consulting specialists.
3. Respondent failed to assess and treat appropriately an open wound on Patient A's leg.

4. Respondent failed to perform adequate physical examinations of Patient A.

5. Respondent failed to obtain adequate medical history for Patient A.

6. Respondent failed to maintain a medical record which adequately reflected the treatment rendered to Patient A.

B. On or about and between December 13, 2004 and September 6, 2005, Respondent treated Patient B, who was a 28 year-old male at the onset of treatment. Respondent treated Patient B at his office in Brooklyn, New York. Respondent's care of Patient B deviated from minimum accepted standards of care in that:

1. Respondent failed to assess and treat adequately Patient B's complaints of pain, including but not limited to:

   a. Failing to attempt non-pharmacological modes of pain management;

   b. Inappropriately prescribing pain medication;

   c. Inadequately monitoring Patient A's use of pain medication.

   d. Failing to assess the efficacy of treatment.

2. Respondent failed to perform adequate physical examination of Patient B.

3. Respondent failed to obtain adequate medical history for Patient B.

4. Respondent failed to maintain a medical record which adequately reflected the treatment rendered to Patient B.

C. On or about and between July 10, 2001 and July 22, 2005, Respondent treated Patient C, who was a 27 year-old female at the onset of treatment. Respondent treated Patient C at his office in Brooklyn, New York. Respondent's care of Patient C deviated from minimum accepted standards of care in that:

1. Respondent failed to assess and treat adequately Patient C's complaints of pain, including but not limited to:
   a. Failing to obtain appropriate diagnostic testing;
   b. Inappropriately prescribing pain medication.
2. Respondent failed to assess, diagnose and treat adequately Patient C's possible thyroid condition, including but not limited to:
   a. Failing to obtain appropriate laboratory tests;
   b. Inappropriately prescribing medication.
3. Respondent failed to perform adequate physical examination of Patient C.
4. Respondent failed to obtain adequate medical history for Patient C.
5. Respondent failed to maintain a medical record which adequately reflected the treatment rendered to Patient C.

D. On or about and between January 14, 2002 and September 1, 2005, Respondent treated Patient D, who as a 21 year-old female at the onset of treatment. Respondent treated Patient D at his office in Brooklyn, New York. Respondent's care of Patient D deviated from minimum accepted standards of care in that:

1. Respondent failed to assess and treat adequately Patient D's complaints of pain, including but not limited to:
   a. Failing to obtain appropriate diagnostic testing;
   b. Inappropriately prescribing pain medication.
2. Respondent failed to perform adequate physical examination of Patient D.
3. Respondent failed to obtain adequate medical history for Patient D.
4. Respondent failed to maintain a medical record which adequately reflected the treatment rendered to Patient D.

E. On or about and between August 16, 2004 and May 25, 2005, Respondent treated Patient E, who as a 27 year-old female at the onset of treatment. Respondent treated Patient E at his office in Brooklyn, New York. Respondent's care of Patient E deviated from minimum accepted standards of care in that:

1. Respondent failed to assess and treat adequately Patient E's complaints of pain, including but not limited to:
   a. Failing to obtain appropriate diagnostic testing;
   b. Inappropriately prescribing pain medication.
2. Respondent failed to adequately assess Patient E's possible hypothyriodism.
3. Respondent failed to perform adequate physical examination of Patient E.
4. Respondent failed to obtain adequate medical history for Patient E.
5. Respondent failed to maintain a medical record which adequately reflected the treatment rendered to Patient E.

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 two or more of the following:

1. Paragraphs A, A1 through A5; B, B1 through B3; C, C1 through

C4; D, D1 through D3; and E, E1 through E4.

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 two or more of the following:

2. Paragraphs A, A1 through A5; B, B1 through B3; C, C1 through C4; D, D1 through D3; and E, E1 through E4.

THIRD 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 care and treatment of the patient, as alleged in the facts of:

3. Paragraphs A6, B4, C5, D4 and E5.

DATE: May 4, 2009
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct