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NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 14, 2011

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael G. Bass, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2438
Albany, New York 12237-0032

Anthony J. LaFache, Esq.
288 Genesee Street
Utica, New York 13502

Fadi Bejjani, M.D.
Cedars Occupational Physical
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100 Genesee Street
New Hartford, New York 13413

Fadi Bejjani, M.D.
REDACTED

RE: In the Matter of Fadi Bejjani, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 11-219) 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.

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

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

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

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

Fadi Bejjani, M.D.
NYS license # 176944

regarding charges of violations of NYS Ed.L 6530

Determination and Order

BPMC # 11-219

COPY

Before a hearing committee for the State Board for Professional Medical Conduct:

Charles J. Vacanti, M.D., Chair
Therese G. Lynch, M.D.
William W. Walence, Ph.D.

John Harris Terepka, Administrative Law Judge

Held at: New York State Department of Health
335 East Main Street
Rochester, New York 14604
April 15, 2011
259 Monroe Avenue
Rochester, New York 14607
May 2, 3, 23, 2011

Deliberations held July 25, 2011

Parties: New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2505
Empire State Plaza
Albany, New York 12237
By: Michael G. Bass, Esq.

Fadi Bejjani, M.D.
REDACTED

By: Anthony J. LaFache, Esq.
288 Genesee Street – Suite #2
Utica, New York 13502

JURISDICTION

As is set forth in Public Health Law 230(1)&(7) and Education Law 6530, the legislature created the State Board for Professional Medical Conduct in the Department of Health (the Department), and authorized it to conduct disciplinary proceedings in matters of professional medical conduct.

A notice of hearing and statement of charges, both dated March 1, 2011, were served on Respondent Fadj Bejjani, M.D. The hearing was scheduled pursuant to the provisions of PHL 230(10) and hearing procedures set forth in Department of Health regulations at 10 NYCRR Part 51. The statement of charges alleged professional misconduct in violation of New York State Education Law 6530.

The Respondent submitted an answer to the charges pursuant to 10 NYCRR 51.5. (Respondent Exhibit A.) A pre-hearing conference pursuant to 10 NYCRR 51.9(c)(9) was held on April 8, 2011.

EVIDENCE

Witnesses for the Petitioner:	Patient A REDACTED Anthony F. Zumpano Rajeev K. Patel, M.D.
Petitioner exhibits:	Department Exhibits 1-17.
Witnesses for the Respondent:	Edward Yost, M.D. Rebecca Trancgo-Evans, M.D. Rinoo V. Shah, M.D. Sebina Aljucik Fadi J. Bejjani, M.D.
Respondent exhibits:	Respondent Exhibits A, B, H.
ALJ Exhibits:	ALJ Exhibits I-II.

A transcript of the proceedings was made. (Prehearing conference transcript, pages 1-30; Hearing transcript, pages 1-1112.)

THE CHARGES

The statement of charges (Exhibit 1) included eight specified charges of misconduct as defined in various subsections of Ed.L 6530. The charges were based on factual allegations made in connection with the Respondent's treatment of ten patients (Patients A – E, G - K.) The factual allegations fall into four groups:

1. Patient A. The Respondent is accused of verbally harassing Patient A by engaging her in conversation of an inappropriate personal, non-medical nature during a single office encounter in which she sought treatment for back and neck pain.
2. Patient B. The Respondent is accused of inappropriate actions regarding emergency medical care and documentation of it given to Patient B, injured in a motor vehicle accident directly outside of the Respondent's office.
3. Patients C, D, E, G. The Respondent is accused of inappropriately prescribing controlled substances for patients without making adequate attempts to treat the patients' chronic pain by other means, and of routinely refilling those prescriptions prematurely without documenting an explanation.
4. Patients H, I, J, K. The Respondent is accused of inappropriately performing and documenting the need for various procedures relating to spinal conditions; specifically discography, nucleoplasty, caudal epidural injections and intradiscal electrothermal therapy (IDET).

The Petitioner withdrew all allegations with regard to Patient F. (Petitioner brief, pages 2, 19.) The Petitioner also withdrew two allegations regarding Patient H (H1, H2) and one allegation regarding Patient I (I2). (Petitioner brief, pages 21, 25.)

Regarding the credibility of the witnesses, the Hearing Committee came to the following general conclusions:

Dr. Patel: The Committee generally credited Dr. Patel, the Petitioner's witness on medical issues. The Committee noted that when he was shown evidence to the contrary he readily changed his mind, which led to the Petitioner's withdrawal of two factual allegations. (Petitioner brief, page 3.) To the extent the Committee disagreed with Dr. Patel's findings, it was largely because the Committee came to different conclusions about what the medical records actually documented.

Dr. Shah: The Committee found Dr. Shah, the Respondent's witness, to be credible on most medical issues, but somewhat evasive in his responses regarding appropriate indications for nucleoplasty procedures.

Dr. Yost: Dr. Yost spoke in general terms in support of the Respondent and about the sedation issue with Patient K, but he was not involved in any of the procedures under review and so the Committee found his testimony, while credible, to be of minor significance.

Dr. Trangco-Evans and Sebina Aljukic: The Committee had little reason to doubt their sincerity and general credibility, but gave little weight to their testimony simply because they had little of significance to say about any of charges.

Dr. Bejjani: The Committee did not find the Respondent to be a credible witness, as is further discussed elsewhere in this decision.

Patient A was found to be highly credible and her testimony was given great weight, as is further discussed elsewhere in this decision.REDACTED was also found to be credible. Captain Zumpano was found to be generally credible but his testimony was given little weight because he was not present for important parts of the incident he described.

FINDINGS OF FACT

The following findings of fact were made upon unanimous vote of the Hearing Committee. Citations are to evidence found persuasive by the Committee. All of the evidence was reviewed, however, and conflicting evidence, if any, was considered and rejected in favor of the evidence supporting the Committee determination.

1. Respondent Fadi Bejjani, M.D., was authorized to practice medicine in New York State on January 3, 1989 under license number 176944. (Department Exhibit 2.) His medical practice includes minimally invasive spine surgery and pain management. (Exhibit B.)

Patient A.

2. Patient A, a 35 year-old female, appeared at an appointment with the Respondent on July 15, 2008 at his Utica office for an electromyogram (EMG). (Transcript, pages 22-23; Exhibit 3, pages 2-3.) The purpose of an EMG is to identify nerve damage or nerve pain. (Transcript, pages 109-110.)

3. At times during the EMG, Patient A was alone in the examination room with the Respondent. (Transcript, pages 24, 35, 880.)

4. Patient A told the Respondent that bruises on her arms were from riding horses, to which Respondent replied "do you ride bulls...because I'm a Taurus." (Transcript, pages 25, 935.)

5. The Respondent told Patient A that he had a talented tongue, and stuck out and wiggled his tongue at her. (Transcript, page 27.)

6. The Respondent asked Patient A if she had any nerve issues or tingling such as in her nipples, and rubbed his own nipples. (Transcript, page 31.)

7. The nurse who referred Patient A to the Respondent for the EMG was named Deb, Debbie or Deborah. (Transcript, pages 26, 1027.) The Respondent told Patient A that "they call her Deb—Debbie does Dallas," thereby referring to a pornographic film, and made comments about her breasts to the effect that "she used to be up here, but now she's sagging down there." (Transcript, page 26.)

8. The Respondent raised his eyebrows at Patient A several times and told her that his employees had left for the day. (Transcript, pages 28, 31.)

9. The Respondent told Patient A she needed to be seen again and made an appointment with her for the next day at 5 pm. (Transcript, pages 32, 75, 1027.)

10. The Respondent made the appointment with Patient A directly, and not through his staff. (Transcript, page 63.)

11. The Respondent's employees had not left for the day. (Transcript, pages 35, 49.)

12. The Respondent persistently asked Patient A to go to dinner with him after their office appointment. (Transcript, pages 26-27.) He also told her he would take her out to dinner after their appointment the next day. (Transcript, page 32.)

13. After her encounter with the Respondent, Patient A drove home, "contemplated for a little while," and called her sister and spoke to her brother-in-law about it. (Transcript, pages 33, 66, 69.)

14. Patient A called Respondent's office the next day to cancel her appointment, and was told by staff that there was no such appointment in the office book. (Transcript, page 32.)

Patient B.

15. Patient B was injured in a motor vehicle accident outside Respondent's office on June 27, 2006. The Respondent came out of his office to assist. (Exhibit 4; Transcript, pages 79-82.)

16. The Respondent talked with Patient B before emergency medical services personnel arrived, and administered or ordered his staff to administer injections of Versed and Toradol. (Transcript, pages 869, 940-41; Exhibit 4 page 16.)

17. The Respondent failed to document his treatment of Patient B. (Transcript, pages 881-82.)

Patients C, D, E and G.

18. The Respondent provided medical care for Patient C at his Utica office at various times from October 23, 2003 to January 14, 2009 for leg and back pain. (Exhibit 5.)

19. The Respondent provided medical care for Patient D at various times from February 17, 2004 to June 23, 2008 at his Utica Office for pain, including facial pain, pain from a previously broken leg, low back pain, and carpal tunnel syndrome. (Exhibit 6.)

20. The Respondent provided medical care for Patient E at his Utica office at various times from May 10, 2005 to January 24, 2008, primarily for lower back pain. (Exhibit 7.)

21. The Respondent provided medical care for Patient G at his Utica office at various times from November 5, 2003 to October 17, 2007, primarily for back pain. (Exhibit 9.)

22. The Respondent regularly prescribed various narcotic pain medications for all of these patients. The medications included Oxycontin, oxycodone, morphine, Lortab, Kadian, Avinza, and Fentora. (Exhibits 5, 6, 7, 9.)

Patients H, I, J and K.

Patient H.

23. The Respondent provided medical care to Patient H at his Utica office and at Little Falls Hospital from September 15, 2004 to February 14, 2005. Patient H had been diagnosed with cervical disc displacement with radiculitis and lumbar disc displacement with radiculitis. (Exhibit 10.)

24. Patient H had been in a motor vehicle accident in 2001, and her treatment history included occipital nerve injections, aquatherapy, a TENS unit, and medication including Lidoderm, nortriptyline, and hydrocodone.

25. On October 18, 2004, the Respondent performed a multi-level lumbar discogram on Patient H. (Exhibit 10, page 18.)

26. A discogram (discography) is a diagnostic test to identify what are known as concordantly painful structural discogenic lesions. It is a test to identify if an intervertebral disc is causing a patient's pain. (Transcript, pages 171-72, 584.)

27. On November 8, 2004, Respondent performed an L2-3 disc decompression nucleoplasty on Patient H. (Exhibit 10, page 43.)

28. A nucleoplasty is a procedure in which a spine "wand" is introduced into the nucleus, or the center part of the disc to create channels, essentially creating a negative pressure to bring a disc herniation back into place. (Transcript, pages 178, 583.) The nucleoplasty procedure is indicated for pinched nerve pain with radiating pain down a leg due to a herniated disc. The purpose is to take pressure off of a nerve. It is not indicated for discogenic pain, that is, an incompetent painful disc. (Transcript pages 178-79, 194-95, 249-

50, 335-36.) An MRI is an appropriate diagnostic test for disc herniation. (Transcript, pages 195, 196-97.)

29. Patient H's record does not document any indication of a herniated disc. (Transcript, pages 631, 1043.)

Patient I.

30. The Respondent provided medical care to Patient I at various times from September 13, 2002 to October 15, 2003 at his Utica office and at Little Falls Hospital. Patient I had been diagnosed with back pain. (Exhibit 12.)

31. On September 15, 2003, the Respondent performed a caudal epidural injection on Patient I. (Exhibit 12, page 10.)

32. A caudal epidural injection is an injection intended to introduce pain medications into the lower back. (Transcript, page 696.)

33. Patient I's medical record documents a significant history of low back pain. The patient had had epidural procedures in the past. (Exhibit 12, page 37.)

Patient J.

34. The Respondent provided medical care to Patient J at several offices from July 22, 2002 to September 29, 2003. Patient J had a history of low back pain. (Exhibit 13.)

35. On September 2, 2003, the Respondent performed intradiskal electrothermal therapy (IDET) on Patient J. (Exhibit 13, page 44.)

36. IDET is a procedure that is performed on a structurally incompetent disc in order to improve the structural integrity of the disc and to provide pain relief. (Transcript, pages 198, 239-40.)

37. Indications for IDET are based on a discogram. (Transcript, pages 240-41.)

38. While a there is no copy of a relevant discogram report in Patient J's medical record, the record does document that a discogram report was reviewed by the Respondent before performing the IDET. (Transcript, page 241; Exhibit 13, page 35.)

39. On September 2, 2003, the Respondent performed an L3-4 percutaneous decompression nucleoplasty procedure on Patient J. (Exhibit 13, page 44.)

40. The decompression nucleoplasty procedure is indicated for pinched nerve pain with radiating pain down a leg due to a herniated disc. The purpose is to take pressure off of a nerve. It is not indicated for discogenic pain, that is, an incompetent painful disc. (Transcript pages 178, 249-50, 335-36.)

41. Patient J's medical records do not document a herniated disc. (Transcript, pages 198, 1046-47.)

42. On September 29, 2003, the Respondent performed a caudal epidural injection on Patient J. (Exhibit 13, page 43.)

43. Patient J's medical record documents a significant history of low back pain. A caudal epidural injection can be indicated for low back pain relief. (Transcript, pages 696-98.)

Patient K.

44. The Respondent provided medical care to Patient K at his Utica office and at Little Falls Hospital at various times from October 22, 2003 to December 29, 2003. (Exhibits 14, 15.)

45. Patient K had been in a severe motor vehicle accident in February 2003, resulting in spinal injury. Her medical history included MRI's of the neck, back and thoracic spine that showed annular tears at L4-5 and L5-S1, disc herniation at C5-6, annular tear at C4-5, and degenerative disc at C6-7. (Exhibit 15, page 7; Transcript, page 258.)

46. On October 22, 2003, Respondent performed a discogram on Patient K. (Exhibit 15, page 18.)

47. A discogram is performed by introducing needles into a number of disc levels and requires a patient response. It is a painful procedure for the patient. (Transcript, pages 171-72.)

48. An anesthesiologist administered sedation during the discogram procedure. (Exhibit 15, page 15.)

49. Physician and anesthesiologist both participate in decisions regarding sedation of a patient. (Transcript, page 534.)

50. There is no evidence that the sedation interfered with the performance or the results of the discogram on Patient K.

51. On November 10, 2003, the Respondent performed an L3-4 percutaneous decompression nucleoplasty on Patient K. (Exhibit 16, page 11.)

52. Nucleoplasty is a done to take the pressure off of a spinal nerve. (Transcript, page 333.) It is not an appropriate procedure to address the results of a discogram indicating an incompetent, painful disc. (Transcript, pages 263-4, 331-32.)

53. Patient K's record does not document any indication of a herniated disc disc at L3-4. There is documentation of a herniation at C5-6. (Transcript, page 656; Exhibit 15, page 7.)

DETERMINATION ON FACTUAL ALLEGATIONS

Patient A.

The Committee sustained all six of the Petitioner's specific factual allegations, as is set forth with particularity in fact findings 4-9 and 12 herein.

The Committee found Patient A highly credible and believed her story. Art Mayhew credibly corroborated her account that she made prompt complaints about this incident. The Committee considered particularly revealing the evidence that the Respondent made the return appointment directly with Patient A himself, and not through office staff. The "appointment" turned out not to have been a real office appointment, as Patient A learned when she called the next day to cancel and was told by office staff that there was no appointment in the book.

The Respondent denied the accusations of flagrant behavior with his tongue, which he claimed involved a misunderstood reference to his being multilingual. He denied making reference to a pornographic film. The accusations of suggestive use of his hands regarding breasts and nipples, and raised eyebrows, were claimed to be simply distorted accounts of his body language. He acknowledged mentioning that he was a Taurus but denied mentioning anything about bull riding. He said, regarding the allegations that he invited Patient A to dinner, that he was referring only to the presence of food in the office kitchen, which he regularly offered for the use of staff and patients who were undergoing stressful tests.

The Committee credited Patient A's account over that of the Respondent, who the Committee found, in general, not to be credible. He was evasive when asked about his resume, complaint history or any issues he did not want to talk about. In regard to the Respondent's honesty, regard for truth telling, and credibility in general, the Committee also took a dim view of his attempt at the hearing to coach a witness while that witness was testifying. (Transcript, pages 807-808.)

The Respondent testified that he routinely uses jocular conversation to "distract and entertain" patients who are undergoing painful diagnostic tests, and said "I tried to be

especially gregarious and affable" with Patient A. (Transcript, pages 903-904.) This explanation does not excuse his behavior during this encounter.

Patient B.

The Petitioner charges that on June 27, 2006 the Respondent provided emergency medical care in an inappropriate manner to Patient B. Patient B, a stranger to the Respondent, was injured in a motor vehicle accident directly outside the Respondent's office. According to the Petitioner the Respondent treated him at the scene with injections of Versed and Toradol without obtaining the patient's consent, without sufficient indication for the treatment, and without conducting and documenting an appropriate history and physical examination of the patient.

The Respondent acknowledges that injections of Versed and Toradol were given to the patient upon his instructions. He maintained that he took the patient's blood pressure, took a brief medical history and asked about allergies. (Transcript, pages 869, 940-41.) He said he did not make a written record but asked the patient to return to see him for follow up, and planned to document everything then. The patient did not come back. (Transcript, page 942.)

The Petitioner relied principally on the testimony of Captain Zumpano, who was an emergency medical services responder at the scene. The committee found Captain Zumpano generally credible, but he arrived at the accident scene after the Respondent. (Transcript, page 79.) He acknowledged that he did not know to what extent the Respondent had already engaged with the patient, and acknowledged that the appropriate steps could have been taken before he arrived. (Transcript, pages 87, 89.) The patient did not testify or give a statement, nor did he make any complaint about the incident. Captain Zumpano's hearsay account of

what Patient B said about his encounter with the Respondent was not deemed to prove by a preponderance of the evidence that the Respondent failed to conduct an adequate evaluation of the patient before treating him. (Transcript, page 84.)

The Petitioner made three factual allegations:

Allegation B1 is that the Respondent gave the injections of Versed and Toradol without sufficient, and documented, indication for doing so. The Committee unanimously voted not to sustain allegation B1 because it was proved only to the extent it duplicates allegation B3, the documentation failure.

Allegation B2 is that the Respondent treated Patient B without his consent. The Committee concluded that, taking into account the emergency circumstances, the Petitioner failed to prove consent was not obtained. The Committee unanimously voted not to sustain allegation B2.

Allegation B3 is that the Respondent treated Patient B without documenting a history, physical examination or rationale for the treatment. It is uncontroverted that the Respondent failed to document his encounter with and treatment of the patient. His excuse that he expected the patient to return in a few days, at which time a full documented workup would have been done is rejected. His inconsistent suggestion that he did make a record but mailed it off to the Department of Health years ago is not credible. (Transcript, page 1033.)

The Respondent was not necessarily required to document the encounter as it was occurring, but should at the very least have made some kind of reasonably contemporaneous notation, that day or soon thereafter. It is the point of a contemporaneous record that it is made when knowledge of the event is fresh. This purpose would in no way be served by

sitting down with the patient days later even if he did return. The Committee unanimously voted to sustain allegation B3.

Patients C, D, E and G.

The factual allegations are the same for all four patients. There are two allegations for each patient. The Committee did not sustain any of the allegations.

Factual allegations C1, D1, E1 and G1 criticized the Respondent for repeated treatment with controlled substances with "no or suboptimal" attempts at treatment with other pain management modalities.

It is clear that the allegation of "no" attempts is wildly inaccurate. The Committee agreed that these were long term patients with long histories of pain treatment and had all been through other treatment modalities – including at the Respondent's behest. The charts reflect this. Even Dr. Patel acknowledged that the Petitioner did meet the minimal standard of care with Patient E. (Transcript, page 429.) Petitioner having failed to meet its burden of proof the Committee unanimously voted not to sustain these four allegations.

Factual allegations C2, D2, E2 and G2 criticized the Respondent for repeatedly refilling 30 day prescriptions for controlled substances before earlier prescriptions were completed.

The accusation is not of any wholesale or haphazard refilling of prescriptions. The criticism is that the Respondent occasionally wrote prescription refills a few days before previous prescriptions had been entirely used up. The Respondent said that a slight variation in dates of prescriptions was insignificant and that simple reference to a calendar would generally show that weekends, holidays and other such things explained it. He also said there was no concern in writing these prescriptions a few days early as pharmacies would not

refill the prescriptions early anyway. The Petitioner did not even attempt to address these points.

The Petitioner's accusation of apparent "skimming" appears to be based entirely on Dr. Patel's anecdotal impression of the charts. (Transcript, pages 354-55, 394, 417, 439.) In its proposed findings of fact, the Petitioner alleges "over a dozen" occasions of refill prescriptions written a few days early for Patient C in over five years; "Over a dozen" such occasions for Patient D in over four years; "On several occasions" for Patient E in over two years; and "On several occasions" for Patient G in almost four years. (Petitioner's brief, proposed fact findings 63, 69, 76, 83.) This is hardly an alarming scenario. Dr. Patel conceded that the evidence does not suggest that anything inappropriate was actually happening in connection with these refills. (Transcript, page 363.) There is no evidence that any prescription was actually filled before the previous one had been exhausted, nor did the Petitioner attempt to show that any of these patients obtained more than their appropriate regimens because of the dating variations on the refill prescriptions. (see Transcript, page 952-53.) The Committee unanimously voted not to sustain these allegations.

Patients H, I, J and K.

The Petitioner charges that the Respondent inappropriately performed various procedures relating to spinal conditions: lumbar discography, disc decompression nucleoplasty, caudal epidural injection and intradiskal electrothermal therapy (IDET).

The Committee sustained only the factual allegations H4, J2 and K3, all for decompression nucleoplasty.

Discography

Factual allegations H3 and K1 criticized the Respondent for performing lumbar discography without a documented medical indication. These patients had both been in serious automotive accidents and had been in pain. The Committee unanimously voted not to sustain these allegations.

Factual allegation K2 also criticized the Respondent for performing the discogram on October 22, 2003 despite the fact that the patient was sedated. The Respondent said the issue was whether the patient could reliably answer the questions, not whether the patient was sedated, and said that he never proceeded unless the patient could adequately respond. There is no evidence that the sedation interfered with the performance of the test. The Committee unanimously voted not to sustain the allegation.

Decompression nucleoplasty

Factual allegations H4[1], J2 and K3 criticized the Respondent for performing decompression nucleoplasty without a documented medical indication. There was a significant difference of medical opinion between Dr. Patel and the Respondent on what constitutes appropriate documented indication for this procedure. Dr. Shah, while testifying in support of the Respondent, was somewhere in the middle and not entirely convincing in his support of the Respondent's claims.

Dr. Patel was adamant that discogram results cannot provide justification for a nucleoplasty procedure because they do not identify any problem that nucleoplasty can address. (Transcript, pages 249-50, 263-64, 331-32.) He consistently maintained that

[1] Factual allegation H4 criticized the Respondent for performing decompression nucleoplasty at both L2-3 and at L4-5 without a documented medical indication. The Respondent did not perform this procedure at L4-5 as originally charged. (Exhibit 10, page 43.) The allegation regarding L4-5 is dismissed.

nucleoplasty is indicated for pinched nerve pain due to a herniated disc and is not indicated on the basis of an incompetent painful disc with no evidence of herniation. The Respondent did not dispute Dr. Patel's assertion that none of these charts documents a herniated disc.

Dr. Shah testified that the nucleoplasty was done with sufficient medical indication in these instances, but did not persuasively explain just what that documented indication was other than to say that there is no standard of care, only guidelines for such a procedure. (Transcript, pages 609-10.) He claimed Patient H had a herniated disc on the basis of an MRI report that was not in evidence and was in any event apparently for Patient I. (Transcript, pages 230, 629-30.) He then agreed, as did the Respondent, that the patient records for Patients H and for Patient K contained no documented indication of lumbar herniation. (Transcript, pages 631, 656, 1043.) He was repeatedly evasive when asked directly about Dr. Patel's main criticism that nucleoplasty is not indicated in the absence of evidence of herniation causing nerve pressure, answering instead:

Q. Now, Doctor, in fact, nucleoplasties should only be performed when there's a disc herniation; is that correct?

A. No.

Q. Okay.

A. It's a contraindication in some situations to perform nucleoplasty on a disc herniation. (Transcript, page 631.)

...

Q. And, basically, what it says is that you should only be doing nucleoplasties when there's a herniated disc, correct?

A. A herniated disc can be a contraindication for a nucleoplasty. (Transcript, page 633.)

...

Herniated disc means different things. Okay? They're different criteria. If anybody testifies that nucleoplasty's indicated for herniated disc, that's negligence. Okay? Herniations mean different things. (Transcript, page 657.)

In this manner Dr. Shah repeatedly evaded direct answers when asked if evidence of herniation was the primary justification for nucleoplasty, by responding instead that there are circumstances where herniation is not always an indication for nucleoplasty. This begs the question what was the indication for nucleoplasty in the cases under review. Similarly, asked for the basis of his opinion whether nucleoplasty was performed without sufficient medical indication on Patient K, he answered: "First and foremost, decompression nucleoplasty procedures can potentially be performed without having the added rigor of a discogram." (Transcript, page 649.) He then praised the "higher level rigor" of performing a discogram as well as the nucleoplasty in this case, again without convincingly explaining what the medical indication for the nucleoplasty was to begin with. (Transcript, pages 649-50.)

The Respondent claimed a "positive discogram" and six weeks of conservative treatment for pain as his documented justification for all three of the nucleoplasty procedures criticized in this case. (Transcript, pages 914, 978, 988-89, 997-98, 1040, 1062, 1068-69.) He claimed Patient J "could be" herniated at L4-5 and L5-S1, which is not the area where the procedure under review was done. (Transcript, page 998.) He also claimed Patient K was "about to start herniating" at L3-4. (Transcript, page 1046.) He defended these procedures, however, solely on the basis of the discograms and histories of pain even in the absence of herniation. He agreed that "positive discography" in itself is not an indication of a herniated disc. (Transcript, page 1065.) He denied, however, that evidence of herniation was a necessary indication for nucleoplasty. Dr. Patel testified to the contrary. The Committee credited Dr. Patel on the basis of the consistency of his testimony, the equivocation in Dr. Shah's testimony, and the Respondent's general lack of credibility.

The Hearing Committee voted 2-1 to sustain factual allegation H4, and voted 3-0 to sustain factual allegations J2 and K3.

Caudal epidural injection

Factual allegations I1 and J3 criticized the Respondent for performing caudal epidural injections without a documented medical indication.

The Petitioner conceded the allegation I1 "appears to be, primarily, a documentation issue." (Petitioner's brief, page 25.) Dr. Shah's testimony (Transcript, pages 697-99), and the documentation in the chart, persuaded the Committee that given Patient I's history of low back pain and epidural procedures in the past as well as a previous MRI, the evidence failed to meet the Petitioner's burden of proving the treatment was not appropriate. A significant documented history of low back pain led the Committee to the same conclusion with regard to Patient J. The Committee unanimously voted not to sustain the allegations.

Intradiskal electrothermal therapy (IDET)

Factual allegation J1 criticized the Respondent for performing IDET (intradiskal electrothermal therapy) on September 2, 2003 without a documented medical indication. The Petitioner's charge was based on the claim that a discogram was a prerequisite to establish a need for this procedure. A discogram report is not in the chart but mention of it is. The Petitioner conceded this is a documentation issue, not a deviation from the accepted standard of care in the procedure itself. Dr. Patel agreed that he "would not have a problem with the IDET" if a discogram report showing a reason for it was done, and that it is "not an un – totally unreasonable thing to do." (Transcript, pages 244-45, 251-53.) His only real criticism, then, concerned the "mild issue" of the documentation. The Committee accepted

the documentation indicating that the discogram was in fact performed and reviewed, and unanimously voted not to sustain the allegation.

DETERMINATION ON SPECIFICATIONS OF CHARGES

Definitions of professional misconduct applicable to physicians are set forth in Ed.L 6530 and 6531. In this case, the Respondent has been charged with eight specifications of misconduct pursuant to Ed.L 6530:

First specification. The Petitioner charges that the Respondent violated Ed.L 6530(4) by practicing with gross negligence on a particular occasion.

The only sustained factual allegation in support of this charge was B3, the Respondent's failure to document his encounter with and treatment of Patient B. The Committee determined that the Respondent's failure to document his actions in this emergency situation did not rise to the level of gross negligence. The Committee voted unanimously that this charge is not sustained.

Second specification. The Petitioner charges that the Respondent violated Ed.L 6530(6) by practicing with gross incompetence.

The only sustained factual allegation in support of this charge was B3, the Respondent's failure to document his encounter with and treatment of Patient B. The Committee determined that the Respondent's failure to document his actions in this emergency situation did not rise to the level of gross incompetence. The Committee voted unanimously that this charge is not sustained.

Third specification. The Petitioner charges that the Respondent violated Ed.L 6530(3) by practicing with negligence on more than one occasion.

The sustained factual allegations in support of this charge were A1(a-f), B3, H4, J2 and K3. The Committee voted unanimously to sustain negligence on more than one occasion in connection with the nucleoplasty procedures forming the basis for allegations H4, J2 and K3. The Committee voted 2-1 that the factual allegations A1(a-f), concerning the Respondent's conduct with Patient A, also established negligence. The Committee unanimously voted that allegation B3, concerning the Respondent's failure to document his treatment of Patient B, did not constitute an instance of negligence. The Committee voted unanimously that the charge of negligence on more than one occasion is sustained.

Fourth specification. The Petitioner charges that the Respondent violated Ed.L 6530(5) by practicing with incompetence on more than one occasion.

The sustained factual allegations in support of this charge were also A1(a-f), B3, H4, J2 and K3. The Committee unanimously agreed that none of these sustained allegations established incompetence. The Committee voted unanimously that this charge is not sustained.

Fifth specification. The Petitioner charges that the Respondent violated Ed.L 6530(20) by engaging in conduct which evidences moral unfitness to practice medicine.

The sustained factual allegations in support of this charge were A1(a-f), the Respondent's conduct with Patient A. The Committee voted 2-1 that the sustained allegations established moral unfitness. The charge is sustained.

Sixth specification. The Petitioner charges that the Respondent violated Ed.L 6530(31) by willfully harassing a patient verbally.

The sustained factual allegations in support of this charge were also A1(a-f). The Committee voted unanimously that the evidence established willful harassment of a patient. The Committee voted unanimously that this charge is sustained.

Seventh specification. The Petitioner charges that the Respondent violated Ed.L 6530(26) by performing a professional service which had not been duly authorized by the patient or his legal representative. No factual allegations cited in support of this charge were sustained. The charge is dismissed.

Eighth specification. The Petitioner charges that the Respondent violated Ed.L 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

The sustained factual allegations in support of this charge were B3, H4, J2 and K3. The Committee voted unanimously to sustain the charge on the basis of allegation B3, the Respondent's failure to document his treatment of Patient B. The Committee voted unanimously not to sustain it regarding allegations H4, J2 and K3, the nucleoplasty procedures. The Committee voted unanimously that this charge is sustained.

PENALTY DETERMINATION

The Hearing Committee unanimously determined that a penalty should be imposed for the sustained charges of negligence on more than one occasion, moral unfitness, and willful harassment of a patient. The Committee unanimously agreed that no penalty should be imposed on the basis of the sustained charge of failure to maintain a record, and so did not consider that charge in connection with the penalty determination.

The Committee reviewed the penalties available to it under PHL 230-a. The Committee's primary concern was to fashion a penalty that addressed and reflected the

Respondent's conduct with Patient A. The Committee agreed that some action with regard to Respondent's license was appropriate, and so imposes a two year suspension, but limits the actual suspension to two months. In order to most directly address the concerns raised by the Respondent's conduct with Patient A and to ensure appropriate conduct with patients in the future, the Committee also imposes a practice limitation in the form of a chaperone requirement subject to terms and conditions approved by the Director of OPMC. This penalty determination is made by unanimous vote of the Hearing Committee.

ORDER

IT IS HEREBY ORDERED THAT:

1. The third, fifth, sixth and eighth specifications of misconduct under Ed.L 6530(3), (20), (31) and (32) are sustained.

2. The Respondent's license to practice medicine is suspended for a period of two years. The suspension shall be stayed after the first two months.

3. The Respondent shall, in the course of practicing medicine in New York State, examine and/or treat any patient only in the presence of a chaperone. The chaperone shall be proposed by Respondent and subject to the written approval of the Director of OPMC in accordance with terms and conditions established by the Director.

4. This order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required under PHL 230(10)(h).

Dated: PITTSFORD, New York
10 September 2011 By: REDACTED

Charles J. Vacanti, M.D., Chair

Therese G. Lynch, M.D.
William W. Walence, Ph.D.

To: Michael G. Bass, Esq., Associate Counsel
Bureau of Professional Medical Conduct
Corning Tower, Empire State Plaza
Albany, New York 12237-0032

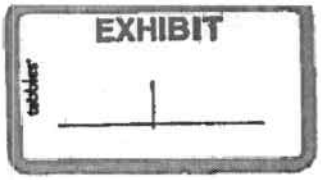
Anthony J. LaFache, Esq.
288 Genesee Street
Utica, New York 13502

Fadi Bejjani, M.D.

REDACTED

Fadi Bejjani, M.D.
Cedars Occupational Physical Pain & Spine Medical
100 Genesee Street
New Hartford, New York 13413

APPENDIX I



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

IN THE MATTER

OF

FADI BEJJANI, M.D.

NOTICE

OF

HEARING

TO: FADI BEJJANI, M.D.

REDACTED

FADI BEJJANI, M.D.
Cedars Occupational Physical Pain & Spine Medical
100 Genesee Street
New Hartford, New York 13413

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 April 15, 2011, at 10:00 a.m., at the Offices of the New York State Department of Health, Conference Room 4, 335 East Main Street, Rochester, New York 14604, 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 MGB

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. JAMES F. HORAN, ACTING 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: Albany, New York
March / ,2011

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:

MICHAEL G. BASS
Assistant Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower, Room 2505
Albany, New York 12237
(518) 473-4282

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

IN THE MATTER

OF

FADI BEJJANI, M.D.

STATEMENT

OF

CHARGES

FADI BEJJANI, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 3, 1989, by the issuance of license number 176944 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the attached appendix), a 35 year old female, at Cedars Occupational Physicians Pain & Spine Medicine, 311 Turner Street, Utica, New York 13501 [hereinafter "Utica Office"] on or about July 15, 2008. Patient A had experienced a nerve injury in her back and was at Respondent's office to have a electromyography performed. Respondent's care and treatment of Patient A failed to meet accepted standards of medical practice in that:

1. Respondent, during the visit of July 15, 2008, engaged in conversation with the patient of a personal and non medical nature, including:

   a. Asking her if she "rode bulls" and that he was a "Taurus", or words to that effect;

   b. Told her that he had a "very talented tongue", or words to that effect and then wriggled his tongue at her;

   c. Asked her if she had any pain in her nipples, rubbed his own nipples as he asked the question;

   d. In discussing the nurse that had referred her to Respondent, Respondent made reference to the pornographic film "Debbie Does Dallas" then indicated that "she used to be perky", or words to that effect as he held his hands in front of his chest

then stated, "but now she's sagging", or words to that effect as he dropped his hands to imply low breasts;

e. Told her that his staff had left for the day as he repeatedly raised his eyebrows;

f. Told her that he would make a follow up appointment for her the following day at 5:00PM, after the office was closed, then he would take her to dinner.

B. Respondent, having no prior contact with Patient B, a 27 year old male, provided medical care outside of his Utica Office for Patient B immediately after Patient B been involved in a motor vehicle accident in the vicinity of Respondent's Utica Office on or about June 27, 2006. Respondent's care and treatment of Patient B failed to meet accepted standards of medical practice, in that:

1. Respondent provided Patient B with Versed and Toradol despite there being insufficient indication for such treatment and/or without documenting such indication.

2. Respondent treated Patient B with Versed and Toradol without obtaining the consent of Patient B for such treatment.

3. Respondent treated Patient B with no documentation of a history, physical examination or any kind of written documentation explaining the rationale for his treatment of Patient B.

C. Respondent provided medical care for Patient C, a 57 year old male, at his Utica Office, at various times from on or about October 23, 2003 to on or about January 14, 2009. Respondent's care and treatment of Patient C failed to meet accepted standards of medical practice in that:

1. Respondent, on repeated occurrences in his care of Patient C from on or about October 23, 2003 to on or about January 14, 2009, made no or suboptimal attempts at the utilization of non -controlled pain management analgesics and adjuvant physical modalities in therapeutics for chronic pain management control.

2. Respondent, on repeated occurrences in his care of Patient C from on or about October 23, 2003, to on or about January 14, 2009, failed to

adequately document the refilling of controlled substances prior to the prior prescription being completed.

D. Respondent provided medical care for Patient D, a 45 year old female, at his Utica Office, at various times from on or about February 17, 2004, to on or about June 23, 2008. Respondent's care and treatment of Patient D failed to meet the accepted standards of medical practice in that:

1. Respondent, on repeated occurrences in his care of patient D from on or about February 17, 2004, to on or about June 23, 2008, made no or suboptimal attempts at the utilization of non-controlled pain management analgesics and adjuvant physical modalities in therapeutics for chronic pain management control.

2. Respondent, on repeated occurrences in his care of Patient D from on or about February 17, 2004, to on or about June 23, 2008, failed to adequately document the refilling of controlled substances prior to the prior prescription being completed.

E. Respondent provided medical care for Patient E, a 46 year old male, at his Utica Office, at various times from on or about May 10, 2005 to January 24, 2008. Respondent's care and treatment of Patient E failed to meet accepted standards of medical practice in that:

1. Respondent, on repeated occurrences in his care of Patient E from on or about May 10, 2005, to on or about January 24, 2008, made no or suboptimal attempts at the utilization of non-controlled pain management analgesics and adjuvant physical modalities in therapeutics for chronic pain management control.

2. Respondent, on repeated occurrences in his care of patient E from on or about May 10, 2005, to on or about January 24, 2008, failed to adequately document the refilling of controlled substances prior to the prior prescription being completed.

F. Respondent provided medical care for patient F, a 58 year old female, at his Utica Office, at various times from on or about April 6, 2006, to on or about May 16, 2007. Respondent's care and treatment of patient F failed to meet accepted standards of medical practice in that:

1. Respondent, on repeated occurrences in his care of Patient F from on or about April 6, 2006, to on or about May 16, 2007, made no or suboptimal attempts at the utilization of non-controlled pain management analgesics and adjuvant physical modalities in therapeutics for chronic pain management control.

2. Respondent, on repeated occurrences in his care of Patient F from on or about April 6, 2006, to on or about May 16, 2007, failed to adequately document the refilling of controlled substances prior to the prior prescription being completed.

G. Respondent provided medical care for Patient G, a 57 year old female, at his Utica Office, at various times from on or about November 5, 2003, to on or about October 17, 2007. Respondent's care and treatment of Patient G failed to meet accepted standards of medical practice in that:

1. Respondent, on repeated occurrences in his care of Patient G from on or about November 5, 2003, to on or about October 17, 2007, made no or suboptimal attempts at the utilization of non-controlled pain management analgesics and adjuvant physical modalities in therapeutics for chronic pain management control.

2. Respondent, on repeated occurrences in his care of Patient G from on or about November 5, 2003, to on or about October 17, 2007, failed to document the refilling of controlled substances prior to the prior prescription being completed.

H. Respondent provided medical care to Patient H, a 45 year old female, at his Utica Office and Little Falls Hospital, Little Falls, New York 13365 [hereinafter "LFH"], at various times from on or about September 15, 2004 to on or about February 14, 2005. Respondent's care and treatment of Patient H failed to meet accepted standards of medical practice, in that:

1. Respondent, on or about October 18, 2004, inappropriately performed a caudal epidural injection prior to a lumbar discography on Patient H.

2. Respondent, on or about October 18, 2004, performed a caudal epidural injection on Patient H without sufficient medical indication for such a procedure and/or without documenting such medical indication.

3. Respondent, on or about October 18, 2004, performed a lumbar discography on Patient H without sufficient medical indication for such a procedure and/or without documenting such medical indication.

4. Respondent, on or about November 8, 2004, performed a percutaneous disc decompression nucleoplasty at L2-L3 and L4-L5 on Patient H without sufficient medical indication for such a procedure and or without documenting such medical indication.

I. Respondent provided medical care to Patient I, a 56 year old male, at his Utica Office and LFH at various times from on or about September 13, 2002 to on or about October 15, 2003. Respondent's care and treatment of Patient B failed to meet accepted standards of medical practice, in that:

1. Respondent, on or about September 15, 2003, performed a caudal epidural injection on Patient I without sufficient medical indication for such a procedure and/or without documenting such medical indication.

2. Respondent, on or about October 8, 2003, performed a caudal injection on Patient I without sufficient medical indication for such a procedure and/or without documenting such medical indication.

J. Respondent provided medical care to Patient J, a 41 year old male, at his Utica Office, LFH and Spine and Sports Medicine, 7883 Seneca Turnpike, Clinton, NY 13323 & 2208 Genesee Street, Utica, NY 13502 at various times from on or about July 22, 2002 to on or about September 29, 2003. Respondent's care and treatment of Patient J failed to meet accepted standards of medical practice, in that:

1. Respondent, on or about September 2, 2003, performed intradiskal electrothermal therapy on Patient J without sufficient medical indication for such a procedure and/or without documenting such indication.

2. Respondent, on or about September 2, 2003, performed a percutaneous decompression nucleoplasty procedure on Patient J without sufficient medical indication for such a procedure and/or without documenting such indication.

3. Respondent, on or about September 29, 2003, performed a caudal epidural injection procedure on Patient J without sufficient medical indication for such a procedure and/or without documenting such indication.

K. Respondent provided medical care for Patient K, a 36 year old female,

at his Utica Office and LFH at various times from on or about October 2, 2003 to on or about December 29, 2003. Respondent's care and treatment of Patient K failed to meet accepted standards of medical practice, in that:

1. Respondent, on or about October 22, 2003, performed a discogram on Patient K without sufficient medical indication for such a procedure and/or without documenting such indication.

2. Respondent, on or about October 22, 2003, performed a discogram on Patient K despite the fact that Patient K was sedated.

3. Respondent, on or about November 10, 2003, performed a nucleoplasty on Patient K without sufficient medical indication for such a procedure and/or without documenting such indication.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

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

1. The facts in paragraphs B and B.1, B and B.2, B and B.3, and/or H and H.1.

SECOND SPECIFICATION
GROSS INCOMPETENCE

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

2. The facts in paragraphs B and B.1, B and B.2, B and B.3, and/or H and H.1.

THIRD 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:

3. The facts in paragraphs A and A.1(a), A and A.1(b), A and A.1(c), A and A.1 (d), A and A.1(e) A and A.1(f), B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, G and G.1, G and G.2, H and H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3.

FOURTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASSION

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:

4. The facts in paragraphs A and A.1(a), A and A.1(b), A and A.1(c), A

and A.1(d), A and A.1(e), A and A.1(f), B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, G and G.1, G and G.2, H an H.1, H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, J and J.1, J and J.2, J and J.4, K and K.1, K and K.2, K and K.3.

FIFTH SPECIFICATION
MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530 (20) engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine, as alleged in the facts of the following:

5. The facts in paragraphs A and A.1(a), A and A.2(b), A and A.1(c), A and A.1(d), A and A.1(e), and/ or A and A.1(f).

SIXTH SPECIFICATION
WILLFULL HARASSMENT OF A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530 (31) by willfully harassing a patient verbally, as alleged in the facts of the following:

6. The facts in paragraphs A and A.1(a), A and A.1(b), A and A.1(c), A and A.1(d), A and A.1(e), and/or A and A.1(f).

SEVENTH SPECIFICATION
PERFORMING SERVICES WITHOUT AUTHORIZATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(26) by performing a professional service which had not been duly authorized by the patient or his legal representative, as alleged in the facts of the following:

7. The facts in paragraphs B and B.2.

EIGHTH SPECIFICATION
FAILURE TO MAINTAIN A RECORD

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 the following:

8. The facts in paragraphs B and B.1, B and B.3, C and C.2, D and D.2, E and E.2, F and F.2, G and G.2 H and H.2, H and H.3, H and H.4, I and I.1, I and I.2, I and I.2, J and J.1, J and J.2, J and J.3, K and K.1, and/or K and K.3.

DATED: March 1, 2011

REDACTED

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct