NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 23, 2019

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

David W. Quist
Associate Attorney
Bureau of Professional Medical Conduct
Division of Legal Affairs
NYS Department of Health
Corning Tower, Room 2512
Empire State Plaza
Albany, New York 12237

Dennis Gruttadaro, Esq.
Brown, Gruttadaro & Prato, PLLC
Hale House
19 Prince Street
Rochester, New York 14607

Sudipt Sureshchandra Deshmukh, M.D.
c/o Dennis Gruttadaro, Esq.
Brown, Gruttadaro & Prato, PLLC
Hale House
19 Prince Street
Rochester, New York 14607

**RE: In the Matter of Sudipt Sureshchandra Deshmukh, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 19-264) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

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

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|---|---|
| IN THE MATTER<br>OF<br>SUDIPT SURESHCHANDRA DESHMUKH, M.D. | DETERMINATION<br>AND<br>ORDER<br>19-264 |

Pursuant to New York State Public Health Law (PHL) § 230(10)(d)(i), the New York State Department of Health, Bureau of Professional Medical Conduct (Department) served Sudipt Sureshchandra Deshmukh, M.D. (Respondent) with a Notice of Hearing and Statement of Charges. The hearing was held at the offices of the New York State Department of Health, located at 217 South Salina Street, Syracuse, New York. **ANDREW J. MERRITT, M.D.**, Chairperson, **ELEANOR C. KANE, M.D.**, and **PAUL J. LAMBIASE**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to PHL § 230(10)(e).[1] **TINA M. CHAMPION**, Administrative Law Judge, served as the Administrative Officer.

The Department appeared by David W. Quist, Associate Attorney and Nathanial C. White, Associate Counsel. The Respondent appeared by Dennis Gruttadaro, Esq. and William Kalish, Esq. Evidence was received, witnesses were sworn or affirmed, and a transcript of the proceeding was made.

[1] Mr. Lambiase was appointed to replace original Hearing Committee Member Janet M. Miller, R.N. after the first day of hearing when she became unable to serve on the committee any longer. Dr. Kane was appointed to serve as a Hearing Committee Member after the last date of the hearing and before deliberations when original Hearing Committee Member and Chairperson Trevor A. Litchmore passed away. Dr. Merritt was present for all hearing dates and was appointed to assume the role of Chairperson after the last day of the hearing and before deliberations. Pursuant to PHL § 230(10)(f), Mr. Lambiase and Dr. Kane have affirmed under penalty of perjury that they have read and considered the evidence and transcripts of the proceedings prior to their appointments.

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

## PROCEDURAL HISTORY

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| Notice of Hearing and Statement of Charges: | October 16, 2018 |
| Pre-Hearing Conference: | November 13, 2018 |
| Hearing Dates: | November 20, 2018<br>February 26, 2019<br>April 10, 2019<br>April 11, 2019 |
| Witness for Department: | Roger E. Scott, D.O., FACP |
| Department Exhibits: | 1-37 |
| Witness for Respondent: | Jane Salamone, M.D. |
| Respondent Exhibits: | B |
| Amended Statement of Charges: | May 31, 2019 |
| Written Submissions Received: | May 31, 2019<br>June 14, 2019 |
| Deliberations Held: | July 10, 2019 |

## STATEMENT OF CASE

The Department initially charged the Respondent with nine specifications of professional misconduct under NY Educ. Law § 6530 involving the Respondent's care of four patients. Subsequent to the last hearing date and without opposition from the Respondent, the Department amended the charges to conform to the proof offered at the hearing. The amended charges are based on the same theories of misconduct as the original charges.

The Department recommends that the Respondent's license to practice medicine be revoked. The Respondent requests that if the Hearing Committee sustains any of the charges

against him, then disciplinary action not exceed a censure and reprimand, the imposition of coursework in medical documentation and patient care strategies, a period of probation with practice monitoring, and a monetary fine. A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix I.

## FINDINGS OF FACT

The following findings are the unanimous determinations of the Hearing Committee after consideration of the entire record in this matter. Numbers in parentheses refer to exhibits (Ex.) or transcript page numbers (T.).

1. The Respondent was authorized to practice medicine in New York State on August 2, 1994 by issuance of license number 196756 by the New York State Education Department. (Dept. Ex. 4.)

2. The Respondent, at all times relevant to the proceedings in this matter, practiced medicine at Long Pond Internal Medicine, a hospital-owned internal medicine practice in Rochester, New York. (T. 12, 625-626.)

3. At various times from about April 2006 to August 2015, the Respondent evaluated and treated Patients A through D for complaints of chronic pain as well as other conditions. (Dept. Exs. 6, 10, 15, 23, 37; Resp. Ex. B.)

4. The standard of care for treating patients presenting with complaints of pain includes taking a good history of the patient, discussing with the patient the symptoms of his or her pain, performing a physical exam, a review of systems, and performing tests to confirm the exam. Under certain circumstances, some of those steps may be omitted. A physician should then engage in medical decision-making to formulate an assessment and plan based on the information gathered from those steps. (T. 30, 331-332.)

5. A physician must document his examination of the patient. (T. 333, 341-342.)

6. A physician must document the assessment and treatment plan for a patient as it is important to understand the reason for a diagnosis and why a particular treatment was selected. (T. 342-343.)

7. Failing to document the treatment plan for a patient that includes treatment with medications increases the risk of harm from side effects and polypharmacy, as well as a risk of receiving inappropriate or insufficient medication, due to a lack of information as to why a patient is on a particular medication. (T. 342-343.)

8. The standard of care for prescribing medication includes having and documenting adequate medical indication for that particular medication. How a physician reached a decision on a treatment option and a summary of the risks and benefits as discussed with the patient should be documented. Such documentation is necessary as a reminder to the physician regarding the reasons for prescribing, and as necessary information to explain treatment decisions to other providers involved in the patient's care. This standard of care has not changed over the time period at issue in this matter. (T. 34-35, 340.)

9. Prescribing pain medication without adequate medical indication poses risks to the patient including overdose, respiratory suppression, intoxication, and death. Failing to document medical indications for prescribing could pose similar risks. (T. 338-341.)

10. A physician is responsible for his own prescribing, even if another provider had also prescribed medications to a patient. (T. 339.)

11. Treatment of chronic pain with medication carries with it the concern for long-term side effects and, in particular, long-term treatment with opioids carries a risk of dependency on the medication. (T. 32-33.)

12. The standard of care for long-term opioid therapy is to closely monitor the patient, especially for abuse and misuse, utilizing measures such as pill counts and urine drug screens. The standard evolved from 2008 to 2012 to become much more stringent with monitoring. (T. 30-31.)

13. The standard of care for determining whether a patient is an appropriate candidate for opioid therapy has not significantly changed over the time period at issue in this matter. (T. 31.)

14. A physician should address evidence of substance abuse or diversion with a patient and an agreement should be reached with the patient. Any subsequent evidence of misuse or diversion of medications should then be addressed by weaning the patient off the medication or assisting with referring the patient to a different provider. The standard of care for a physician addressing evidence of substance abuse or diversion by a patient has not changed significantly during the time periods at issue in this matter (last 10-15 years). (T. 333-337.)

15. A patient's refusal to follow treatment recommendations from a pain management physician is an indicator that the physician should consider changing the patient's plan of care. (T. 156.)

16. Long Pond Internal Medicine switched from paper medical records to electronic medical records in January 2011 and most physicians, including the Respondent, had difficulty with the new electronic system given the "big learning curve" involved. (T. 635-636.)

**Patient A**

17. The Respondent provided medical care to Patient A from on or about April 11, 2008 until on or about January 27, 2015 for conditions including fibromyalgia, attention deficit disorder, chronic pain, and depression. (Dept. Ex. 6.)

18. Patient A, a female, was 33 years old when the Respondent first began providing care on April 11, 2008. (Dept. Ex. 6.)

19. The Respondent saw Patient A for generalized pain on September 17, 2010, during which visit he examined Patient A and located multiple trigger points. It is appropriate to recheck a patient diagnosed with fibromyalgia and trigger points for trigger points at any follow-up appointment for medication or treatment relating to those trigger points. (Dept. Ex. 6 at 190; T. 350-351.)

20. The Respondent saw Patient A for continued fibromyalgia pain on November 22, 2010. The Respondent's examination of Patient A addressed her general appearance, blood pressure, and observation of a skin tag. The Respondent's examination, as reflected in his medical records, did not address the physical areas involved in the pain and he did not check for repeat trigger points. The Respondent noted that the Respondent was "comfortable." At that office visit, the Respondent increased Patient A's prescriptions for Cymbalta (duloxetine) and Percocet (oxycodone-acetaminophen). The increased dosages were not supported as the Respondent did not document Patient A's pain upon an examination on that date, response to previous dosing, or physical examination of the area of pain. (Dept. Ex. 6 at p. 184; T. 351-352, 411-413, 449-450.)

21. Fentanyl is an opioid medication used to treat pain. It carries the risk of overdose, respiratory suppression, constipation, over sedation, and potentiation with other medications or polypharmacy. (T. 363.)

22. The Respondent saw Patient A on March 7, 2011 for a follow-up of her fibromyalgia and depression. The Respondent's examination of Patient A addressed her blood pressure and assessed her general presentation. The Respondent's examination, as reflected in his medical records, did not include a musculoskeletal examination of the area of pain with an examination of trigger points, range of motion, or strength. The Respondent did not specifically question Patient A on her pain and its location and did not perform an examination of the location of pain in order to quantify or qualify the pain. The Respondent did not assess Patient A's mental state. At that office visit, the Respondent started Patient A on fentanyl and continued the Patient's current doses of Percocet and Soma (carisoprodol). The prescribing plan for those medications is not supported by the Respondent's examination of Patient A. The combination of drugs prescribed to Patient A put her at risk of serious injury or death given the risk of potentiation and the synergistic effects of the medications in combination. (Dept. Ex. 6 at p. 180; T. 358-367.)

23. The Respondent saw Patient A on May 17, 2011 for complaints of chronic pain. The Respondent's examination of Patient A consisted of a general assessment of her appearance,

noting that she appeared "disheveled" and "depressed" and a statement that her vitals were stable. The Respondent's examination, as reflected in his medical records, did not include an examination of the area of pain, range of motion, or any degree of a neurological examination. Patient A indicated that her pain medications were not helping and that she was taking more Percocet than what was prescribed. Despite Patient A's overuse of medication and a notation that Patient A should possibly be tapered off her medications, the Respondent did not begin weaning Patient A off pain medications. (Dept. Ex. 6 at p. 174; T. 368-374.)

24. The Respondent saw Patient A on July 21, 2011 and reduced her Percocet dosage upon Patient A indicating a willingness to taper her medications. (Dept. Ex. 6 at 167; T. 374-375.)

25. The Respondent saw Patient A on September 13, 2011 for chronic pain and depression. The Respondent noted that Patient A had a depressed mood and affect, that she moved easily without pain, and that her vitals were stable. The Respondent's examination, as reflected in his medical records, did not include an examination of the area of pain or a musculoskeletal examination. At that office visit, the Respondent increased Patient A's dosage of Percocet. The increased dosage was not supported by the Respondent's examination of Patient A or the Respondent's observation that Patient A moved easily without pain. (Dept. Ex. 6 at p. 141; T. 378-382.)

26. The Respondent saw Patient A on October 31, 2012, at which time Patient A had a recent drug screen that was positive for cocaine. The Respondent wrote Patient A a new prescription for fentanyl, ordered her to get a new drug screen within two days, and indicated that she would not be given any short-acting narcotics until her drug screen was negative. Patient A had a drug screen but not within the two-day window requested by the Respondent and it would not have served the purpose for which it was intended as Patient A would have had time to get clean before undergoing the screen. (Dept. Ex. 6 at 272-279, 288-289; T. 384-388, 451-454.)

27. The Respondent saw Patient A on January 23, 2013. By that office visit Patient A had run out of her medications four days prior from a prescription ordered to cover two weeks. The

Respondent did not confront Patient A about substance abuse or diversion and did not wean her from her medications. (Dept. Ex. 6 at 312-321; T. 388-389.)

28. The Respondent saw Patient A on October 28, 2013. By that office visit Patient A had run out of an oxycodone prescription that was intended to last through November 8, 2013. Despite acknowledging Patient A's misuse of medication, the Respondent did not wean Patient A from her medications. (Dept. Ex. 6 at 503-514; T. 389-392.)

29. The Respondent saw Patient A on April 18, 2014 for a stated follow-up of lumps on her neck and doubled her fentanyl dose without medical indication as the Respondent did not perform a musculoskeletal examination and/or an examination of trigger points. The Respondent's medical decision-making is not documented. (Dept. Ex. 6 at 540-555; T. 392-399.)

30. The Respondent saw Patient A on June 9, 2014. The Respondent's encounter note from that office visit included a drug screen dated April 18, 2014 that showed Patient A tested negative for opiates, benzodiazepines, and oxycodone. Patient A had been prescribed clonazepam, fentanyl, and oxycodone during the period covered by the drug screen and, at a minimum, the clonazepam and oxycodone should have shown up on the screen if the Patient had taken them. The Respondent's records do not reflect that he addressed Patient A's compliance with her, weaned her, or referred her to a substance abuse provider in light of the inconsistent drug screen. (Dept. Exs. 6 at 572-588; 9 at 4-5; T. 399-407.)

31. Based upon the preceding Findings of Fact, during the time frame of November 2010 to June 2014 the Respondent failed to adequately exam Patient A or document such examination, prescribed pain medications to Patient A without medical indication or without documenting such medical indication, failed to adequately address evidence of possible substance abuse or diversion with Patient A or document that he addressed the issue with her, and failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.

**Patient B**

32. The Respondent provided medical care to Patient B from on or about June 4, 2008 through August 6, 2015 for conditions including chronic pain, anxiety, and migraine headaches. (Dept. Ex. 10.)

33. Patient B, a female, was 21 years old when the Respondent first began providing care on June 4, 2008. (Dept. Ex. 10.)

34. During an office visit on June 10, 2010, Patient B told the Respondent that she had tried a friend's Percocet and expressed a desire for the medication. At an office visit on June 23, 2010, Patient B again told the Respondent that she had been using someone else's Percocet and wanted a prescription for that medication. The Respondent prescribed Percocet for Patient B "as she is already using the medication." (Dept. Ex. 10 at pp. 997-998.)

35. On or around May 16, 2012, the Respondent prescribed butalbital to Patient B for daily headaches. The Respondent's office notes do not reflect that the Respondent discussed the risks and benefits of the medication with Patient B. (Dept. Ex. 10 at 30-46; T. 59-61.)

36. On January 24, 2013, the Respondent prescribed fentanyl to Patient B while she was still taking oxycodone. The simultaneous use of fentanyl and oxycodone poses serious risks including over sedation, respiratory compromise, and impairment. The Respondent's office notes do not reflect that Patient B was counseled on the risks associated with using fentanyl or the risks associated with the simultaneous use of fentanyl and oxycodone. (Dept. Ex. 10 at 150-169; T. 65-68.)

37. The Respondent's medical records for Patient B contain a letter dated April 1, 2013 from a nurse practitioner (NP Maxwell) at The Maxwell Boev Clinic, a neurological surgery practice, who wrote refills for Dilaudid (hydromorphone) and Xanax (alprazolam) for Patient B but expressed concern about the patient's heavy usage of narcotics and stated that she wanted Patient B to get back to her baseline narcotic use in a few weeks. (Dept. Ex. 10 at 827.)

38. At an office visit on May 29, 2013, the Respondent increased Patient B's prescription of oxycodone while Patient B was also taking alprazolam, butalbital, cyclobenzaprine, and fentanyl. The combination of those medications poses a risk of over-sedation, impairment, and respiratory suppression leading to death. There is no indication in the Respondent's office records that he had a discussion with Patient B as to the probability that the patient had developed a tolerance to medication and that increasing the medications may increase the patient's tolerance rather than address the patient's pain. (Dept. Ex. 10 at 226-245; T. 68-71.)

39. The Respondent saw Patient B on July 17, 2013. The Respondent recognized of that date that Patient B had a problem with opiate dependence and advised Patient B that her medications may be causing some of her symptoms and increased sensitivity to pain. The Respondent advised Patient B that tapering her medications should be considered but Patient B did not want to taper, and the Respondent did not begin tapering her medications. (Dept. Ex. 10 at 269-287; T. 72-73.)

40. The Respondent saw Patient B on August 19, 2013 and increased Patient B's oxycodone without an adequate physical examination of the patient and despite the patient complaining of symptoms that are possible side effects of the patient's prescribed medications. (Dept. Ex. 10 at 309-326; T. 74-76.)

41. The Respondent's medical records for Patient B contain a note from a medical doctor (MD Gargano) at Maxwell Boev Medical Group, PLLC who saw Patient B on or about September 5, 2013 for an interventional pain management consultation and assessed that Patient B was suffering from conditions including opioid dependence. MD Gargano suspected that Patient B was suffering from opioid induced hyperalgesia (an increased sensitivity to pain secondary to opiates), indicated that Patient B's doses were higher than she would recommend, suggested gradually weaning Patient B as well as Suboxone therapy. MD Gargano indicated that she would mandate physical therapy, psychological counselling, and random urine toxicology screens to evaluate Patient B for compliance. She declined to assume prescribing for Patient B. The

Respondent's medical records for Patient B do not reflect that he discussed MD Gargano's concerns or treatment recommendations with Patient B. (Dept. Ex. 10 at 832-834; T. 77-81.)

42. The Respondent saw Patient B on October 23, 2013, at which point he discussed the patient's rebound headaches with her and suggested that they were a result of overuse of Fioricet (butalbital). Patient B did not want to reduce her use of Fioricet, and the Respondent maintained her dose rather than wean her. (Dept. Ex. 10 at 361-380; T. 83-85.)

43. The Respondent's medical records for Patient B contain records from a medical doctor (MD Pettee) at Greater Rochester Neurological Associates, P.C. who saw Patient B on or about May 7, 2014 for a reevaluation of the patient's headaches and additional complaints of low back pain, arm and hand jerking, and difficulty with memory and balance. MD Pettee suspected that Patient B's headaches were aggravated by narcotic and analgesic tolerance rebound and opined that ideally both the narcotics and butalbital should be restricted. The Respondent's medical records for Patient B do not reflect that he discussed MD Pettee's concerns or treatment recommendations with Patient B. (Dept. Ex. 10 at 843-844; T. 81-83.)

44. The Respondent saw Patient be on August 25, 2014 and increased Patient B's fentanyl dosage from a 75 micrograms per hour patch to a 100 micrograms per hour patch. The Respondent's note from that office visit indicates that Patient B continued to have back pain but that an MRI did not show any worsening of her back disease and that upon exam there was "no sign of distress" with the patient's appearance. (Dept. Exs. 10 at 606-629; 11 at 6; T.88-91.)

45. Based upon the preceding Findings of Fact, during the time frame of June 2010 to August 2014 the Respondent prescribed pain medications to Patient B without medical indication or without documenting such medical indication, prescribed medications to Patient B without adequately informing her of the risks associated therewith or without documenting that he informed her of the risks, failed to adequately respond to concerns raised by other medical providers regarding Patient B's medications or document that he responded to the concerns, and failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

**Patient C**

46. The Respondent provided medical care to Patient C from on or about April 7, 2006 through December 24, 2014 for conditions including chronic pain. (Dept. Ex. 15.)

47. Patient C, a male, was 48 years old when the Respondent first began providing care on April 7, 2006. (Dept. Ex. 15.)

48. Patient C was on a dose of one to two Percocet 10/325 (10 milligrams oxycodone and 325 milligrams acetaminophen) per day when he initiated treatment with the Respondent on April 7, 2006. The Respondent's medical records reflect that Patient C had changed doctors to be treated by the Respondent because he was "discharged from the pain clinic in October and since then his primary care physician has refused to fill his prescriptions for his OxyContin" (oxycodone). Patient C claimed that he is in "constant pain." The Respondent restarted Patient C on OxyContin at a dose of 80 milligrams twice a day as well as hydrocodone. (Dept. Ex. 15 at 681-682.)

49. Simultaneous prescribing of carisoprodol and alprazolam is contraindicated due to the possible interaction increasing the risk of respiratory suppression. (T. 285.)

50. Simultaneous prescribing of oxycodone, carisoprodol, pregabalin, and alprazolam poses a high risk of death or serious injury to a patient by creating the potential for respiratory suppression and intoxication. (T. 300-301.)

51. Simultaneous prescribing of oxycodone, hydrocodone, and alprazolam poses a risk of overdose, abuse, sedation or over sedation, respiratory suppression, serious injury, and death. The risks are present when the medication is consumed orally, and the risk of death increases if the medications are snorted. (T. 304-305, 311-312.)

52. The Respondent saw Patient C on May 25, 2007. The Respondent noted that Patient C had used more oxycodone than was prescribed and stated that Patient C was "addicted to his medications and he probably needs to get off these medications in the future." The Respondent started an additional oxycodone prescription of Oxy IR (oxycodone) in addition to continuing his OxyContin prescription. (Dept. Ex. 15 at 656-657; T. 201-203.)

53. The Respondent saw Patient C on June 25, 2007. The Respondent noted that Patient C was using more oxycodone than was prescribed and that Patient C wanted his prescription increased. The Respondent did not note any discussion with Patient C about taking medication as directed or an examination of the patient. The Respondent increased Patient C's prescription for oxycodone. (Dept. Ex. 15 at 655; T. 201-203.)

54. The Respondent saw Patient C on February 3, 2012 and started him on a prescription for fentanyl. The Respondent's medical records do not contain documentation of medical decision making for starting fentanyl, and do not reflect that the Respondent considered weaning Patient C from his pain medications or referring Patient C for substance abuse counselling. (Dept. Ex. 15 at 9-19; T. 204-208.)

55. The Respondent saw Patient C on June 21, 2012 and noted that there was a need to "cut back on the narcotics given his inconsistent response to large doses," however the Respondent increased the maximum daily dose of Patient C's oxycodone prescription upon the Patient's request. The Respondent failed to recognize or act on any recognition of Patient C's request for an increase in his prescription indicating abuse of the medication. (Dept. Ex. 15 at 39-52; T. 210-211.)

56. The Respondent saw Patient C on January 23, 2013 at which time he prescribed pregabalin to Patient C while having also prescribed oxycodone and carisoprodol. Simultaneous prescribing of pregabalin with oxycodone and carisoprodol poses a significant polypharmacy risk of sedation or over sedation, impairment, respiratory suppression, significant harm, and death to Patient C. The Respondent's medical records from that office visit do not indicate that he discussed those risks with Patient C. (Dept. 15 at 60-67; T. 212-214.)

57. The Respondent saw Patient C on January 17, 2014. As of this office visit, the Respondent decided to taper Patient C's oxycodone dosage by ten percent every seven to ten days. At subsequent office visits the patient requested to defer tapering and the Respondent abandoned the plan to taper. (Dept. Ex. 15 at 102-150; T. 214-231.)

58. The Respondent saw Patient C on May 12, 2014. As of this office visit the Respondent had significantly decreased Patient C's dosage of oxycodone but added oxymorphone to Patient C's medications. The addition of oxymorphone was counterproductive to weaning Patient C from opiate medications and the Respondent should have continued with the plan to wean Patient C rather than changing his medications. Dept. Ex. 15 at 151-160; T. 222-224.)

59. The Respondent saw Patient C on May 22, 2014. At that office visit Patient C stated he had increased pain and requested that his oxycodone be tapered more gradually. The Respondent increased Patient's C maximum daily dose of oxycodone from 10 milligrams to 15 milligrams. The Respondent's medical records do not indicate an appropriate examination of Patient C. (Dept. Ex. 15 at 161-169; T. 224-227.)

60. The Respondent saw Patient C on June 6, 2014 and documented that Patient C used more oxycodone than was prescribed. Patient C had used a twenty-day supply of oxycodone in fifteen days and requested that his oxycodone dosage be increased. The Respondent increased Patient C's maximum daily dose from 15 milligrams to 20 milligrams. The appropriate medical indication for Patient C was to wean him rather than increase his dosage of oxycodone. (Dept. Ex. 15 at 170-177; T. 227-229.)

61. The Respondent saw Patient C on July 3, 2014 and documented that Patient C requested to increase his oxycodone dosage to a maximum daily dose of 22 milligrams. The Respondent increased it as requested, which was the dosage prescribed to Patient C at Patient C's first taper. The appropriate medical indication for Patient C was to wean him, refer him for substance abuse disorder, and discuss alternatives for pain management rather than increase his dosage of oxycodone. (Dept. Ex. 15 at 102-108, 178-185; T. 229-230.)

62. The Respondent saw Patient C on August 1, 2014 at which time he administered keterolac to Patient C. Use of keterolac in conjunction with the other medications prescribed to Patient C posed a mild risk of gastrointestinal complications. The Respondent's medical records do not reflect that he informed Patient C of that risk. (Dept. Ex. 15 at 186-193; T. 232, 237-238.)

63. Based upon the preceding Findings of Fact, during the time frame of June 2007 to August 2014 the Respondent prescribed medications to Patient C without medical indication or without documenting such medical indication, prescribed medications to Patient C without adequately informing him of the risks associated therewith or without documenting that he informed him of the risks, and failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

**Patient D**

64. The Respondent provided medical care to Patient D from on or about January 19, 2009 until on or about February 6 or March 11, 2014 for conditions including chronic back pain, anxiety, depression, drug dependency and withdrawal, and insomnia. (Dept. Ex. 23.)

65. Patient D, a male, was 25 years old when the Respondent first began providing care on January 19, 2009. (Dept. Ex. 23.)

66. At Patient D's initial office visit on January 19, 2009, Patient D presented complaining of daily headaches and low back pain with pain radiating into his left leg. The Respondent noted that Patient D had a "history of opiate abuse ex-IV drug use." (Dept. Ex. 23 at 460.)

67. Patients presenting with a known history of drug abuse generally should not be treated with chronic opiate therapy or other addictive controlled substances. Prescribing benzodiazepines or sleep aid medications to Patient D put him at risk of respiratory suppression, potentiation, and interaction with other medications. (T. 458-460, 467.)

68. Patient D presented at an emergency room on May 2, 2009. Medical records reflect that Patient D intentionally overdosed, had been kicked out of rehab following a jail stay, told his parents that he wanted to kill himself, and admitted to ingesting multiple prescription drugs, cocaine and heroin. Patient D was observed to have a blue powder on his lips and Ambien (zolpidem) was suspected as the primary overdose agent because of its color being consistent with the blue powder on Patient D's lips. Patient D admitted to using "a lot" of tramadol. Patient

D had a prior suicide attempt and an overdose episode one year earlier. (Dept. Ex. 23 at 492-499.)

69. Patient D's history and condition in which he presented at the emergency room on May 2, 2009 indicated that he was mentally unstable and that he had high risk behaviors with illicit drugs. (T. 471.)

70. Following his emergency room visit, Patient D followed up with the Respondent on May 11, 2009. The Respondent prescribed Ambien for Patient D upon his request. The prescription was contraindicated given Patient D's history, and it posed risks of overdose, addiction, serious harm, and death. (Dept. Ex. 23 at 453; T. 472-474.)

71. Patient D presented at an emergency room on June 1, 2009 with suicidal ideation and a plan to overdose, and stated he was uncomfortable because he was withdrawing from heroin that he had last used the day before. Patient D's uncontrolled drug use demonstrated that he was continuing to engage in risky behavior and use illicit medications. (Dept. Ex. 23 at 487-491; T. 474-475.)

72. Patient D presented at an emergency room on May 13, 2010 secondary to appearing somnolent at a methadone clinic and stated that he had taken an extra Soma, that he used cocaine and heroin the day before, and that he received methadone the day before. Patient D also admitted to using IV drugs but claimed he had been clean until the day prior. (Dept. Ex. 23 at 485-486.)

73. Patient D's history of drug abuse, relapse, and suicidal ideation warrants extreme caution in treating his chronic pain and prescribing any opiates, habit-forming medications, or medications which could cause another relapse. Patient D's pain should have been treated with alternative treatments such as physical therapy, non-addicting therapies, acupuncture, or chiropractic treatments. (T. 478-479.)

74. The Respondent saw Patient D for a follow-up to the May 13, 2010 emergency room visit on May 19, 2010. At that office visit, the Respondent confronted Patient D about his not

informing the Respondent of Patient D's participation in a methadone program, references to heroin and cocaine in the emergency room visit notes, and Patient D prematurely exhausting a prescription for clonazepam. The Respondent properly refused to issue a new prescription for clonazepam, but inappropriately provided a fifteen-day prescription for Lyrica (pregabalin) and Ambien. (Dept. Ex. 23 at 441; T. 480-482.)

75. The Respondent saw Patient D for an office visit on May 31, 2012, at which time Patient D was taking orphenadrine and methadone. The Respondent prescribed Ambien and lorazepam to Patient D at that visit. As of an office visit on August 27, 2012, Patient D was still taking medications including orphenadrine, methadone, Ambien, and lorazepam. Simultaneous use of those medications posed a risk of over-sedation, potentiation, death, or respiratory suppression to Patient D. The Respondent's medical records do not reflect that he discussed the risks of the effects of taking those medications simultaneously with Patient D. (Dept. Exs. 23 at 23-34; 29 at 10-11; T. 482-500.)

76. The Respondent wrote a prescription for baclofen for Patient D, which was first filled on June 29, 2012. The prescription contained five refills, the last of which was refilled on November 1, 2012. The Respondent's medical record does not reflect that Patent D was taking btaclofen during that time period. (Dept. Exs. 23 at 29-34/42; 29 at 15.)

77. The Respondent saw Patient D for an office visit on November 14, 2012 at which time Patient D indicated a desire to reduce his controlled substances and stated that the methadone clinic will be tapering his methadone but requested that the Respondent increase his methadone. The Respondent confronted Patient D about his obtaining alprazolam from a different provider and told Patient D that he would continue to prescribe Lyrica but would no longer prescribe methadone or alprazolam. This action by the Respondent indicates that the Respondent recognized Patient D's manipulation tactics. (Dept. Ex. 23 at 43-48; T. 500-502.)

78. The Respondent saw Patient D on May 3, 2013, at which visit he prescribed Fioricet, a medication that Patient D had also previously been prescribed. Fioricet was contraindicated for

Patient D given his history and because Fioricet is habit forming and could lead to abuse of that medication. It was also contraindicated given that Patient D was also taking tizanidine and could potentiate other central nervous system suppressants such as butalbital. (Dept. Ex. 23 at 72-79; T. 519-522.)

79. The Respondent's medical records for Patient D contain records from a medical doctor (MD Dunn) at Greater Rochester Neurological Associates, P.C. who saw Patient D on or about May 30, 2013 and noted that Patient D had significant rebound headaches due his daily Fioricet use and that Patient D would need to come off of Fioricet. MD Dunn indicated that Patient D was to taper his Fioricet use by one per day each week. (Dept. Ex. 23 at 329.)

80. The Respondent saw Patient D on June 27, 2013 at which time Patient D continued to have daily headaches but did not wish to discontinue his medications and the Respondent continued to prescribe butalbital to Patient D. The continued prescription for Fioricet extended Patient D's risk of rebound headaches and posed a risk of overdose with the possible consequence of death. (Dept. Ex. 23 at 104-111; T. 524-525.)

81. The Respondent saw Patient D on October 30, 2013 at which time Patient D told the Respondent that he wanted to try Lunesta (eszopiclone) for his insomnia and increase his Lyrica. The Respondent wrote Patient D a prescription for Lunesta and increased his Lyrica. Prescribing Lunesta was contraindicated given Patient D's history and posed a risk to Patient D of abuse, overdose and associated central nervous system suppression, and death. Increasing Lyrica was also contraindicated given Patient D's history and the risk of potentiation with other medications. (Dept. Ex. 23 at 156-164; T. 528-534.)

82. The Respondent saw Patient D on November 6, 2013 and noted that Patient D was being manipulative. The Respondent also noted that he was uncomfortable prescribing tramadol but prescribed it anyway, along with Lunesta. Prescribing tramadol was contraindicated given Patient D's history and posed a risk of abuse, dependency, addiction, overdose, severe injury, and death. The Respondent was aware since at least May 2, 2009 that Patient D had a history

of misusing tramadol. At that appointment Patient D complaint of back and leg pain, however the Responded failed to examine or record any examination of the lumbar spine down to areas of pain in the leg to look for signs of disk disease or nerve impingement versus local trauma to the leg. (Dept. Ex.1 23 at 165-173, 492-499; T. 535-540.)

83. As of November 21, 2012, another provider had contacted the Respondent regarding possible redundant prescriptions and the Respondent was aware that another provider suspected that Patient D might be selling his prescriptions. (Dept. Ex. 23 at 263.)

84. The Respondent saw Patient D on December 2, 2013 at which office visit Patient D complained about continued headaches and requested several medications including a refill on his tramadol prescription. The Respondent's notes reflect that he discussed Patient D's manipulative behaviors and dishonesty and suggested that Patient D might be better off treating with a different doctor. The Respondent also told Patient D that "under no circumstances will [the Respondent] prescribe [Patient D] another opiate." The Respondent nonetheless prescribed tramadol, a hybrid opiate, to Patient D at that encounter. The Respondent also prescribed Lunesta to Patient D at that encounter. The Respondent did not wean Patient D or take steps to have him transferred to a different provider. (Dept. Ex. 23 at 196-205; T. 540-544.)

85. The Respondent saw Patient D on December 12, 2013 and prescribed butalbital, Lunesta, and tramadol. The prescription for tramadol was to continue through early February 2014. (Dept. Ex. 23 at 206-214; T. 544-545.)

86. Patient D presented at an emergency room on January 24, 2014 for an intentional overdose. The emergency room notes state methadone and Adderall (dextroamphetamine-amphetamine) as the overdose agents and stated that Patient D was at risk for substance abuse and depression. (Dept. Ex. 23 at 319-322.)

87. The Respondent saw Patient D on February 5, 2014 and confronted Patient D about his untruthfulness and that he ran out of tramadol early. The Respondent again expressed concern over whether he should be Patient D's doctor and told Patient D that he would not give

him any more prescriptions until the following month. However, the following day, on February 6, 2014, Patient D returned to the Respondent's office complaining of pain and requested a prescription for a long-acting form of tramadol. Patient D admitted to having recently used marijuana, codeine, and hydrocodone. The Respondent prescribed tramadol to the patient with a prescription that contained two refills and was to cover a three-month period. This prescription posed a risk of addiction, overdose, diversion, serious harm, and death to Patient D. (Dept. Ex. 23 at 232-249; T. 549-555.)

88. Based upon the preceding Findings of Fact, during the time frame of January 2009 to February 2014 the Respondent prescribed medications to Patient D without medical indication or without documenting such medical indication, prescribed medications to Patient D without adequately informing him of the risks associated therewith or without documenting that he informed him of the risks, and failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

## CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Amended Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (See Prince, Richardson on Evidence § 3-206.) Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established seven of the nine specifications contained in the Amended Statement of Charges. The sustained specifications include professional misconduct by practicing the profession with negligence on more than one occasion [NY Educ. Law § 6530(3)], practicing the profession with incompetence on more than one occasion [NY Educ. Law § 6530(5)], practicing the profession with gross negligence [NY Educ. Law § 6530(4)], practicing the profession with

gross incompetence [NY Educ. Law § 6530(6)], and failing to maintain a record which accurately reflects the evaluation and treatment of the patient [NY Educ. Law § 6530(32)]. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

The Department's expert witness was Roger Scott, D.O., FACP. Dr. Scott is licensed to practice medicine in New York (1998) and Pennsylvania. He graduated from the Philadelphia College of Osteopathic Medicine in 1997. Dr. Scott completed an internal medicine residency at UHS (United Health Services) Hospitals in 2000. He also completed an allopathic residency. Dr. Scott is certified by the American Board of Internal Medicine and the American Board of Osteopathic Medicine and he currently practices in a rural primary care internal medicine practice that also includes treatment of patients with acute and chronic pain. Dr. Scott has spent several years of his career in primary care private practice. He has also had responsibility for training residents, sat on an internal medicine quality committee, and served as the Chief Medical Officer for Cortland Regional Medical Center in Cortland, New York. Dr. Scott has familiarity with the evolution of standards in care relating to pain management from 2000 to the present. (Dept. Ex. 5; T. 19-23, 43.)

Dr. Scott testified on all four days of the hearing in this matter. His testimony was thoughtful, clear, and comprehensive. He readily acknowledged instances when care rendered by the Respondent was within the appropriate standard of care and when the Respondent's prescribing practices and record keeping did not pose a risk or significant risk to a patient. The Hearing Committee finds Dr. Scott to be well-credentialed, his testimony to be very credible, and his opinions on deviations in standard of care to be rendered based on the appropriate standards at the time care was provided.

The Respondent called Jane Salamone, MD, to testify as a fact witness. Dr. Salamone is a board-certified physician who graduated from the University of Rochester Medical School in 1989 and completed her residency in the primary care program at University of Rochester in 1992.

She has practiced at Long Pond Internal Medicine, which is part of Rochester Regional Health, since 1998 and recruited the Respondent to join the practice around 2005. In 2005, Dr. Salamone was the lead physician at Long Pond Internal Medicine. She became the Regional Medical Director in 2008 and the Executive Medical Director in 2017, in which role she has overreaching responsibility for all of the primary care physicians including the Respondent. Her main oversight at Long Pond Internal Medicine is clinical quality. (T. 625-629.)

Dr. Salamone testified about the medical staff composition, patient population, general operating structure, and recordkeeping at Long Pond Internal Medicine. She also testified as to management of patients on long-term opioid therapy at Long Pond Internal Medicine and, in particular, to statistics pertaining to the Respondent's patients. The Hearing Committee appreciates Dr. Salamone's testimony as far as its relevance to understanding the Respondent's patient population and difficulties therewith, and her testimony as to the Respondent's significant improvement with recordkeeping. However, her testimony added little or nothing of benefit to the issue of the specific care provided and medical decision making rendered by the Respondent to Patients A through D.

The Respondent did not call an expert witness to testify and did not testify on his own behalf.

The Department's First Specification charged the Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A through D, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. Bogdan v. State Board for Professional Medical Conduct, 195 A.D.2d 86 (3d Dept. 1993). The Respondent's failure to perform adequate examinations or document such examinations (Patient A), prescribing medications without medical indication or without documenting such medical indication (Patients A – D), failing to adequately address evidence of

possible substance abuse or diversion or document that he addressed the issue with the patient (Patient A), prescribing medications without adequately informing the patients of the risks associated therewith or without documenting that he informed the patients of the risks associated therewith (Patients B – D), failing to adequately respond to concerns raised by other medical providers regarding patient medications or document that he responded to the concerns (Patient B), and failing to maintain a record that accurately reflects the evaluation and treatment of patients (Patients B – D)[2] support a finding of negligence on more than one occasion as those actions and/or omissions by the Respondent are deviations from acceptable medical standards in the treatment of patients. Accordingly, this specification is sustained.

The Department's Second Specification charged the Respondent with professional misconduct for practicing medicine with incompetence on more than one occasion in his care of Patients A through D, in violation of New York Education Law § 6530(5). Incompetence is defined as the lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 609 (3d Dept. 1996). The Respondent's failure to perform adequate examinations or document such examinations (Patient A), prescribing medications without medical indication or without documenting such medical indication (Patients A – D), failing to adequately address evidence of possible substance abuse or diversion or document that he addressed the issue with the patient (Patient A), prescribing medications without adequately informing the patients of the risks associated therewith or without documenting that he informed the patients of the risks associated therewith (Patients B – D), failing to adequately respond to concerns raised by other medical providers regarding patient medications or document that he responded to the concerns (Patient B), and failing to maintain a record that

[2] The Hearing Committee specifically declines to find that the Respondent's failure to maintain a record that accurately reflects the evaluation and treatment of Patient A constitutes negligence under the totality of the circumstances.

accurately reflects the evaluation and treatment of patients (Patients B – D)[3] also support a finding of incompetence on more than one occasion as those same actions and/or omissions by the Respondent demonstrate the Respondent's lack of the requisite skill or knowledge to practice medicine safely. Accordingly, this specification is sustained.

The Department's Third through Fifth Specifications charged the Respondent with professional misconduct for practicing medicine with gross negligence in his care of Patients B through D, respectively, in violation of New York Education Law § 6530(4). Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences. Post v. State of New York Department of Health, 245 A.D.2d 985 (3d Dept. 1997). There is no need to prove that a physician was conscious of the impending dangerous consequences of his conduct. Minielly v. Commissioner of Health, 222 A.D.2d 750 (3d Dept. 1995). The Respondent's failure to respond to concerns raised by other medical providers regarding Patient B's medications by taking measures including but not limited to modifying the patient's medications is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient B. The Respondent's prescribing medications including but not limited to sleep aid medications to Patient D without adequate medical indication, despite knowing that Patient D was taking methadone and muscle relaxants, and despite Patient D's history of drug abuse, as well as failing to document adequate medical indication, is a serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient D. The Respondent's failing to adequately inform Patient D of the synergistic sedative effects of the simultaneous use of opioids, benzodiazepines, muscle relaxants, and sleep medications, as well as failing to adequately document that such information had been provided to Patient D is also a

[3] The Hearing Committee specifically declines to find that the Respondent's failure to maintain a record that accurately reflects the evaluation and treatment of Patient A constitutes incompetence under the totality of the circumstances.

serious deviation from acceptable medical standards which presented a risk of potentially grave consequences to Patient D. In addition to these acts or omissions by the Respondent constituting negligence and incompetence, they rise to the level of gross negligence. Although the Respondent's care of Patient C constitutes negligence and incompetence, the Hearing Committee declines to conclude that the Department met its burden to show that the care rose to the level of gross negligence given the totality of the circumstances. Accordingly, Specifications Three and Five are sustained and Specification Four is not sustained.

The Department's Sixth through Eighth Specifications charged the Respondent with professional misconduct for practicing medicine with gross incompetence in his care of Patients B through D, respectively, in violation of New York Education Law § 6530(6). Gross incompetence is incompetence (the lack of the requisite skill to practice medicine safely) that can be characterized as serious or significant, carrying potentially grave consequences. Dhabuwala, 225 A.D.2d 609; Post, 245 A.D.2d 985. The Respondent's failure to respond to concerns raised by other medical providers regarding Patient B's medications by taking measures including but not limited to modifying the patient's medications is incompetence that presented a risk of potentially grave consequences to Patient B. The Respondent's prescribing medications including but not limited to sleep aid medications to Patient D without adequate medical indication, despite knowing that Patient D was taking methadone and muscle relaxants, and despite Patient D's history of drug abuse, as well as failing to document adequate medical indication, is incompetence that presented a risk of potentially grave consequences to Patient D. The Respondent's failing to adequately inform Patient D of the synergistic sedative effects of the simultaneous use of opioids, benzodiazepines, muscle relaxants, and sleep medications, as well as failing to adequately document that such information had been provided to Patient D is also incompetence that presented a risk of potentially grave consequences to Patient D. In addition to these acts or omissions by the Respondent constituting negligence, incompetence, and gross negligence, they rise to the level of gross incompetence. Although the Respondent's care of Patient C constitutes

negligence and incompetence, the Hearing Committee declines to conclude that the Department met its burden to show that the care rose to the level of gross incompetence given the totality of the circumstances. Accordingly, Specifications Six and Eight are sustained and Specification Seven is not sustained.

The Department's Ninth Specification charged the Respondent with professional misconduct for failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of Education Law § 6530(32). A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v. New York State Dept. of Health, 9 A.D.2d 522 (3d Dept. 2004). On numerous occasions from April 2006 to August 2015, the Respondent failed to document adequate physical examinations (Patient A), failed to document adequate medical indication for prescribing medications (Patients A – D), failed to document that he addressed evidence of substance abuse or diversion (Patient A), failed to document adequately informing patients of risks associated with prescribed medications (Patients B – D), and failed to document that he adequately responded to concerns raised by other health care providers regarding medication (Patient B). The medical records for these four patients are inadequate. The lacking components have resulted in medical records for these patients that provide no support for the Respondent's medical decision-making. These deficient records had the potential to put the patients at risk for serious harm as they failed to convey information that may have been necessary for both the Respondent and another provider to render safe and appropriate treatment. They also demonstrate the Respondent's inability to properly address concerns that are apparent or should be apparent to him, as well as his inability to adequately counsel patients as to risks they may face as a result of a certain course of treatment. Moreover, inadequacies in a physician's medical records has been found to support a finding of negligence on more than one occasion where a relationship between the inadequacies and patient treatment has been shown, as it has been here with respect to Patients B through D. Schoenbach v DeBuono, 262 A.D.2d 820 (3d Dept.

1999); Saunders v Administrative Review Board, 265 A.D.2d 695 (3d Dept. 1999). Accordingly, this specification is sustained.

## DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties.

The Hearing Committee heard testimony it deemed credible from Dr. Scott as to the Respondent's deviations from the appropriate standard of care in place at the time care was rendered. The Respondent did not call an expert witness to opine to the contrary. The Respondent also did not testify despite being present on all four days of the hearing. The Hearing Committee feels it could have benefitted from having heard testimony from the Respondent and having the opportunity to ask him relevant questions, particularly regarding his examinations of Patient A, the discussions he had with Patients A through D, and his reasons for prescribing certain medications and/or quantities of medications.

The Hearing Committee realizes and appreciates that Patients A through D were very difficult patients to treat given their histories, coexisting medical issues, and their chronic pain. The Hearing Committee also appreciates the patient population and volume of patients to whom the Respondent was providing care, and the steps taken within his practice to address and lower his number of patients on chronic opiates. Neither, however, are sufficient reasons to excuse the acts and omissions by Respondent that led to the Hearing Committee sustaining seven out of the nine specifications in this matter.

The Hearing Committee also recognizes the difficulties that many physicians have experienced in switching from recordkeeping in a paper format to electronic record keeping. Upon considering the testimony from Dr. Salamone, the Hearing Committee fully believes that the Respondent has made great strides in this regard. Those improvements, although commendable,

are also insufficient to excuse the potentially dangerous lack of information in the Respondent's medical records for the patients at issue in this matter as discussed above.

The Hearing Committee finds appropriate a 36-month suspension of the Respondent's license to practice medicine, 33 months of which shall be stayed. It also finds appropriate probation with a practice monitor pursuant to the annexed Terms of Probation and the Respondent being restricted to practicing in a group setting during those 33 months following his actual suspension, a permanent limitation on the Respondent's license preventing the Respondent from prescribing controlled substances, and participation in continuing medical education in the area of pharmacology to help him better understand relevant medication issues with his patients.

## ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First, Second, Third, Fifth, Sixth, Eight, and Ninth Specifications of professional misconduct, as set forth in the Amended Statement of Charges, are sustained; and

2. The Fourth and Seventh Specifications of professional misconduct, as set forth in the Amended Statement of Charges, are not sustained; and

3. Pursuant to PHL § 230-a(2)(a), the Respondent's license to practice medicine is wholly suspended for thirty-six (36) months, thirty-three (33) months of which shall be stayed; and

4. Pursuant to PHL § 230-a(9), following the actual three (3) month suspension, the Respondent shall be on probation with a practice monitor and limited to practicing in a group setting for thirty-three (33) months. The terms of probation are annexed hereto; and

5. Pursuant to PHL § 230-a(3), the Respondent's license to practice medicine shall be permanently limited such that he shall not have authority to prescribe any controlled substances; and

6. Pursuant to PHL § 230-a(8), the Respondent shall be required to complete fifty (50) hours of continuing medical education courses in the area of pharmacology per year for each of the three years following the date of this Determination and Order, of which at least ten (10) hours per year shall be on the topics of controlled substances or medicine interactions. The Respondent must submit proof of the same to the Director of the Office of Professional Medical Conduct within thirty (30) days of completing the requisite fifty (50) hours each year; and

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

DATED: Syracuse, New York
October 23, 2019

[redacted]
Andrew J. Merritt, M.D., Chairperson
Eleanor C. Kane, M.D.
Paul J. Lambiase

David W. Quist
Associate Attorney
Bureau of Professional Medical Conduct
Division of Legal Affairs
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

Dennis Gruttadaro, Esq.
Brown, Gruttadaro & Prato, PLLC
Hale House
19 Prince Street
Rochester, New York 14607

Sudipt Sureshchandra Deshmukh, M.D.
c/o Dennis Gruttadaro, Esq.
Brown, Gruttadaro & Prato, PLLC
Hale House
19 Prince Street
Rochester, New York 14607

## TERMS OF PROBATION

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York Education Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York Public Health Law § 230(10) or (19), or both.

2. Respondent shall maintain active registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services and shall pay all registration fees.

3. Respondent shall practice medicine in New York State only when monitored by a licensed physician, board certified in an appropriate specialty (practice monitor), who is proposed by Respondent and subject to the written approval of the Director of the OPMC. The purpose of the practice monitor shall be to review the records of Respondent.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random, unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether Respondent's medical practice is conducted in accordance with generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to the OPMC.

    b. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of the OPMC.

    c. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC within 60 days after the effective date of this Order.

4. Respondent shall practice medicine in New York State only within a group practice setting.

5. Respondent shall provide the Director of OPMC, Riverview Center, 150 Broadway, Suite 355, Albany, New York, 12204, at least every six (6) months and as otherwise requested, and within thirty days of any change in the information, the following in writing:

    a. a full description of Respondent's employment and practice;

    b. all professional and residential addresses and telephone numbers within and outside New York State;

c. all information concerning investigations, arrests, charges, convictions, or disciplinary actions by any local, state, or federal agency; and

d. all information concerning investigations, terminations, or disciplinary matters by any institution or facility.

6. Respondent shall provide to the Director of OPMC copies of all applications relating to the practice of medicine, including but not limited to, privileges, insurance, and licensure, in any jurisdiction, concurrent with submission of the applications.

7. Respondent shall cooperate fully with and respond within two weeks to any OPMC requests to provide written periodic verification of Respondent's compliance with these terms. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

8. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30-day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume, and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in the Determination and Order or as are necessary to protect the public health.

9. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to:

a. a review of office records, patient records, hospital charts, and/or electronic records; and

b. interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

10. Respondent shall comply with these probationary terms and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the State Board for Professional Medical Conduct may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

APPENDIX I

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

IN THE MATTER

OF

SUDIPT SURESHCHANDRA DESHMUKH, M.D.

AMENDED STATEMENT OF CHARGES

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

## FACTUAL ALLEGATIONS

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

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

3. Respondent, on one or more occasions from May 2011 through June 2014, failed to adequately address, and/or failed to document having addressed, evidence of possible substance abuse and/or diversion by Patient A.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.

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

1. Respondent, on one or more occasions from June 2010 through August 2014, prescribed medications including but not limited to fentanyl, butalbital, and/or oxycodone to Patient B without adequate medical indication, and/or without documenting adequate medical indication.
2. Respondent, on one or more occasions, beginning in May 2012, prescribed butalbital to Patient B without adequately informing her of the risk of rebound headache as a side-effect, and/or without documenting that he so informed the patient of this risk.
3. Respondent, on one or more occasions, including but not limited to in January 2013, prescribed fentanyl to Patient B without adequately informing Patient B of the risk of sedation and/or addiction, and/or without documenting that he so informed the patient of these risks.
4. Respondent, despite having been informed in or about April 2013, September 2013 and/or May 2014 of concerns raised by other providers regarding her medications as prescribed by Respondent, failed to adequately respond to such concerns by taking measures including but not limited to adequately modifying his prescribing of such medications to Patient B, and/or to document that such measures were taken.

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

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

1. Respondent, on one or more occasions, from June 2007 through July 2014, prescribed and/or administered various combinations of medications to Patient C, including but not limited to oxycodoneand/or alprazolam without adequate medical indication, and/or without documenting adequate medical indication.
2. Respondent administered ketorolac to Patient C, in or about August 2014, without adequately informing Patient C of the associated risks, and/or failed to document that such information had been provided to Patient C.
3. Respondent, including but not limited to in January 2013, prescribed oxycodone, pregabalin, and and/or carisoprodol to Patient C in various combinations, without informing Patient C of the risk of synergistic sedative effects of the simultaneous use of such medications, and/or without documenting that such information had been provided to Patient C.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C.

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

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

## SPECIFICATION OF CHARGES

### FIRST SPECIFICATION
### NEGLIGENCE ON MORE THAN ONE OCCASION

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

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

and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, and/or D and D.4.

**SECOND SPECIFICATION**
**INCOMPETENCE ON MORE THAN ONE OCCASION**

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

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

**THIRD THROUGH FIFTH SPECIFICATIONS**
**GROSS NEGLIGENCE**

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

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

**SIXTH THROUGH EIGHTH SPECIFICATION**
**GROSS INCOMPETENCE**

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

6. The facts in Paragraphs B and B.4.

7. The facts in Paragraphs C and C.3.

8. The facts in Paragraphs D and D.1 and/or D and D.2.

**NINTH SPECIFICATION**
**FAILURE TO MAINTAIN RECORDS**

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

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

DATE: May 31, 2019
Albany, New York

[redacted]

TIMOTHY J. MAHAR, ESQ.
Deputy Counsel
Bureau of Professional Medical Conduct