STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, 5th Floor Troy, New York 12180-2299

February 2, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Bijoy Sarmaroy, M.D.
34 Sandra Lane
Plattsburgh, New York 12901

RE: In the Matter of Bijoy Sarmaroy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-22) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER

OF

BIJOY SARMAROY M.D.,

Respondent

DETERMINATION

AND

ORDER

BPMC #07-22

A Notice of Hearing and a Statement of Charges, both dated April 17, 2006, were served upon the Respondent, Bijoy Sarmaroy, M.D. **DENISE M. BOLAN, R.P.A.-C. (Chair), WALTER T. GILSDORF, M.D. and RAJAN K. SRISKANDARAJAH, M.D.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Amy B. Merklen, Esq., Assistant Counsel, Bureau of Professional Medical Conduct. The Respondent appeared by Carter, Conboy, Case, Blackmore, Maloney & Laird, John T. Maloney, Esq. of Counsel. Evidence was received, witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Dates of Hearing:	August 2, 2006 September 20, 2006 October 3, 2006
Date of Deliberations:	November 29, 2006

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated four categories of professional misconduct, specifically gross negligence; negligence on more than one occasion; gross incompetence and incompetence on more than one occasion. A copy of the Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are

the unanimous determination of the Committee unless noted by an asterisk. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers and/or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Bijoy Sarmaroy, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about May 11, 1979, by the issuance of license number 138046 by the New York State Education Department. (Ex. 2)

PATIENT A

2. Respondent provided medical care to Patient A at the Champlain Valley Physician's Hospital (hereinafter CVPH) from on or about July 20, 2003 through July 23, 2003. As a result of a motor vehicle accident, Patient

A presented at the CVPH on July 20, 2003 with a diagnosis of a fractured spine at L2-L3, right shoulder dislocation, fracture of the right 5th metatarsal and a laceration of the liver. (T.26-28; Ex. 4)

3. When a patient presents as Patient A did, it is appropriate to admit such a patient to the Intensive Care Unit. After assessing Patient A's condition, the Respondent admitted him to the ICU at CVPH. (T.65-314; Ex. 4)

4. The CVPH did not have the medical capability to handle a grade 4 liver laceration that required interventional radiology or embolization. (T.149-150, 240, 381)

5. On or about July 22, 2003, Patient A's hemoglobin and hematocrit level significantly dropped. When a physician in a hospital such as CVPH has a patient who has a liver laceration, which may be a grade 3 or grade 4 liver laceration and whose hemoglobin and hematocrit drops significantly, that physician should transfer the patient to a facility which has the capability of providing appropriate medical treatment in the event that the patient requires it. The Respondent did not do this on July 22, 2003. (T,573, 575; Ex. 4).

6. When a patient presents to a physician as Patient A did, the physician should from the initiation of care, monitor the patient's hemoglobin and

hematocrit frequently and more that once every 12 hours. The respondent did not do this (T.65-67; Ex.4)

7. When a patient presents to a physician as Patient A did, the physician needs to adequately monitor the patient's tachycardia and treat that condition. As part of the treatment of tachycardia a physician should attempt to determine the etiology of the tachycardia in a timely fashion. The Respondent did not do this.
(T.51, 54, 70-72; Ex. 4)

8. When a patient presents to a physician as Patient A did to the Respondent, a physician should personally evaluate and examine the patient's condition several times a day because the patient was subject to significant blunt trauma. The Respondent did not do this (T.56, 72-73, 247-248; Ex. 4)

9. To adequately treat a patient, a physician should personally review the radiological examination of his patient. The Respondent did not do this with respect to Patient A. (T.31, 73-75, 239, 363, 370 and 558)

10. When a patient presents to a physician as Patient A presented, in order to adequately assess the patient's liver laceration, a physician needs to personally review the radiological examinations relating to the patient to ascertain the location and size of the laceration, the amount of ascites and whether the hepatic vein or vena cava have been displaced in order to justify a classification of the liver laceration. The Respondent did not do this with respect to Patient A. (T.31, 35, 73-75, 239, 363, 370, 373 and 557-558)

PATIENT B

11. Respondent provided medical care to Patient B at the CVPH on or about July 20, 2003. As a result of a motor vehicle accident, Patient B presented at the CVPH on July 20, 2003 with bilateral hemothoraces, displaced thoracic vertebral fractures, fractured ribs on both sides and a fracture dislocation of the hip. (Ex. 5)

12. CVPH was not a level-one trauma center. (T. 300-301, 340-341)

13. When a patient presents such as Patient B presented to the Respondent, it is an appropriate determination that the patient needs to be transferred to a level-one trauma center. (T.435-436, 605-608, 637)

14. Based on all the various medical indications and considerations, Patient B was sufficiently stabilized prior to the transfer to Fletcher Allan Healthcare Center (hereinafter FAHC). (T.169, 605-607, 611-612, 637-638, 641)

15. The insertion of bilateral chest tubes prior to transferring Patient B was not medically required. (T.605-610, 629-630, 635-636)

16. When a patient presents as Patient B did to the Respondent, a physician should address and attempt to treat the patient's signs of tachycardia so as to enable transfer of the patient. The Respondent did this as adequately as possible for Patient B. (T.612-613)

17. Given Patient B's presentation, a physician should evaluate his conditions prior to transport to another facility. The Respondent adequately evaluated Patient B's conditions prior to transfer to FAHC. (T.169, 605-613, 629-630, 635-638 and 641; Ex. 3)

18. To adequately treat a patient, a physician should personally review the radiological examination of his patient. The Respondent did not do this with respect to Patient B. (T.165)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A.3.: (4,5);
Paragraph A.4.: (6);
Paragraph A.5.: (7);
Paragraph A.6.; (8);
Paragraph A 7.: (9);
Paragraph A.8: (10);
Paragraph B.8: (18);

The Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

NEGLIGENCE ON MORE THAN ONE OCCASION

Fifth Specification: (Paragraphs A.3., A.4., A.5., A.6., A.7., A.8., and B.8.).

The Committee voted to **not sustain** the **First through Fourth and Sixth Specifications.**

DISCUSSION

Respondent was charged with violating four subdivisions of professional misconduct within the meaning of Education Law §6530 including gross negligence, negligence on more than one occasion, gross incompetence and incompetence on more than one occasion. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum from the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definitions where applicable as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the specification of negligence on more than one occasion should be sustained. The Committee also concluded that the specifications of gross negligence, incompetence and gross incompetence should not be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented John Fey, M.D., as its sole expert witness. Dr. Fey is board certified in general surgery. There was no evidence of any bias on the part of Dr. Fey or his unsuitability as an expert witness. The Respondent presented

David Handron, M.D. as his sole expert witness. Dr. Handron is board certified in general surgery. There was no evidence of any bias on the part of Dr Handron or his unsuitability as an expert witness.

The Committee found the testimony of Dr. Fey credible in part as it found the testimony of Dr. Handron. Both witnesses were found to have provided their honest medical opinions as to the care provided and were not seen as solely advocates. Their testimony was evenhanded and forthright.

Patient A

The Committee concurred with much of the Department's expert testimony with respect to this patient and the Committee found the care provided this patient to be substandard in a number of areas.

The initial charge that the Respondent provided care to this patient was not sustained since it did not specify how the Respondent did not meet accepted standards of care but merely recited a fact.

The Committee did not find fault with the Respondent admitting the patient to the ICU given his condition at that time. The Committee concluded that this was a judgment call. However, they found that the subsequent drop in his hemoglobin and hematocrit levels on July 22, 2003, should have prompted the Respondent to transfer the patient to FAHC, a level 1 trauma center, which had the capacity to treat a grade 4 liver laceration. The drop in the hemoglobin and

hematocrit levels together with the persistent tachycardia were signs that this patient's condition might develop into something that the Respondent did not have the capacity to treat at CVPH. The Respondent acknowledged he could not provide appropriate care at CVPH for a grade 4 liver laceration, which could potentially develop into an acute blood loss and life threatening consequences.

The Committee also concurred with the Department's expert that the Respondents monitoring of the patient's hemoglobin and hematocrit and tachycardia was inadequate. The checking of vitals every four hours was inadequate. If the protocol at CVPH was to monitor more frequently than the Respondent's orders should have noted as such. The monitoring of the hemoglobin and hematocrit, which was initially every 12 hours and was increased to every 6 hours was inadequate given the patient's injury and the indication of ascites on the radiological tests.

The Committee found the Respondent's level of monitoring and evaluation of the patient, or documentation thereof, to be inadequate. The record was seen as too sparse to allow a subsequent care provider to know what the Respondent was thinking and why. He acknowledged that his "a.m." care for his patient consisted of "eye-balling" the patient. The Committee agreed with the Department's expert that a trauma patient such as this patient should be examined several times a day

and a record should be made of the results of the examination for the benefit of subsequent caregivers.

Of particular significance to the Committee was the Respondent's routine practice of not personally reviewing the radiological tests of his patients. The Committee agreed with Department's expert that a surgeon has a duty to personally view the radiological tests. Even the Respondent's expert testified that he usually reviewed films together with the radiologist. This is underscored by the fact that the Respondent's own expert witness looked at the films before he reached his opinion on the quality of the care provided by the Respondent. In this instant case, this practice of not personally viewing the films resulted in the Respondent not knowing the size or exact location of the liver laceration. Although a surgeon should get input from the radiologist, it is his patient and his decision on what course of care to follow. This complete reliance on the radiologist by the Respondent was found to not meet the standard of care and led to a majority of the Committee concluding that the Respondent failed to adequately assess the patient's liver laceration.

Patient B

The Committee found factual allegations B.1. and B.2., to be statements of fact without any specificity as to how the Respondent's care and treatment did not meet accepted standards of care.

The Committee concurred with the Respondent's expert that the patient was stabilized to the greatest extent, given his conditions, prior to the transfer to FAHC. The Department's own expert testified (T.169) that it was a "judgment call" as to whether to transfer and how stable a physician could get this patient prior to transfer.

The Committee found the testimony of the Respondent's expert convincing on the issue of insertion of bilateral chest tubes. Once again, the insertion of chest tubes was a judgment call that involved weighing the risks and benefits without any clear standard. There was no evidence that a thoracic surgeon was available and a determination was made that the patient needed to be transferred to a level 1 trauma center for appropriate care.

The Committee concurred that although the patient exhibited signs of tachychardia the Respondent addressed his tachychardia as best he could and that based on the risks and benefits, the benefits of transferring him to FAHC where he could get appropriate care outweighed the risks.

The Committee found in this case as in the case of Patient A the Respondent did not personally review the radiological tests of the patient. This failure to personally review the films failed to meet the acceptable standard of care.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent should be Censured and Reprimanded and his license to practice medicine in New York State should be placed **on probation for a period of 1 year**. The terms of the probation are specifically set forth in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee unanimously agreed that the Respondent's license should not be revoked. The record in this case established Respondent was not incompetent but in a number of instances provided substandard care. The Committee felt that the actions of the Respondent warranted placing the Respondent on probation, requiring completion of a CME course on review of radiological tests and monitoring to ensure that his routine practice

includes review of his patients' radiological tests and subsequent consultation with a radiologist when appropriate.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The **Fifth** Specification of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) is **SUSTAINED**;

2. The Respondent is hereby **Censured and Reprimanded**;

3. The Respondent's license is placed on **PROBATION FOR 1 YEAR**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Newcomb, New York
January 29 **, 2007**

Denise M. Bolan, RPA-C
DENISE M. BOLAN, RPA-C (Chair)
WALTER T. GILSDORF, M.D.
RAJAN K. SRISKANDARAJAH, M.D.

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Albany, New York 12237

Bijoy Sarmaroy, M.D.
34 Sandra Lane
Plattsburgh, New York 12901

APPENDIX I

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

IN THE MATTER

OF

BIJOY SARMAROY, M.D.

STATEMENT

OF

CHARGES

BIJOY SARMAROY, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 11, 1979, by the issuance of license number 138046 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Bijoy Sarmaroy, M.D. (Hereinafter "Respondent"), provided care and treatment to Patient A a 22 year old male from on or about July 20, 2003 to approximately July 23, 2003 at Champlain Valley Physicians' Hospital (hereinafter "CVPH") Plattsburgh, New York. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care, in that:

1. Respondent provided care and treatment to Patient A on July 20, 2003 after Patient A was involved in a motor vehicle accident and was transported by ambulance to CVPH Emergency Department.

2. Respondent admitted Patient A to the Intensive Care Unit with a diagnoses of a fractured spine at L2-L3, right shoulder dislocation, fracture of the right 5th metatarsal and a laceration of the liver.

3. Respondent failed to transfer Patient A to Fletcher Allen, a Level 1 Trauma Center, despite medical indication(s).

4. Respondent failed to adequately monitor and/or treat Patient A's hemoglobin and/or hematocrit.

5. Respondent failed to adequately monitor and/or treat Patient A's tachycardia.

6. Respondent failed to adequately evaluate Patient A and/or document such evaluation(s).

7. Respondent failed to review and/or appropriately interpret the significance of Patient A's radiologic examinations and/or document same.

8. Respondent failed to adequately assess the severity of Patient A's liver laceration.

B. Respondent provided care and treatment to Patient B a 34 year old male from on or about July 20, 2003 at CVPH, Plattsburgh, New York. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care, in that:

1. Respondent provided care and treatment to Patient B on or about July 20, 2003 after Patient B was involved in a motor vehicle accident and was transported by ambulance to CVPH Emergency Department.

2. Respondent documented that Patient B had sustained multiple injuries including, but not limited to, bilateral hemothoraces, displaced thoracic vertebral fractures at T9 and T10, fractures of ribs 8 - 11 on the left and rib 11 on the right and a fracture dislocation of the right hip.

3. Respondent determined that Patient B needed to be transferred to Fletcher Allen Health Center, a level one trauma center, for further treatment.

4. Respondent failed to adequately stabilize Patient B prior to transport to Fletcher Allen.

5. Respondent failed to insert bilateral chest tubes in Patient B prior to transport to Fletcher Allen.

6. Respondent failed to adequately treat Patient B's tachycardia prior to transport to Fletcher Allen and/or document same.

7. Respondent failed to adequately evaluate and/or manage Patient B's condition(s) and/or document same prior to Patient B's transport to Fletcher Allen.

8. Respondent failed to review and/or assign the appropriate significance to Patient B's x-rays and/or CT scan.

9. Respondent had Patient B transported despite medical indication(s) that Patient B was not stable.

SPECIFICATION OF CHARGES

FIRST AND SECOND 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 a particular occasion as alleged in the facts of the following:

1. The facts as alleged in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7 and/or A.8.

2. The facts as alleged in paragraphs B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8 and/or B.9.

THIRD AND FOURTH SPECIFICATIONS

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:

3. The facts as alleged in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7 and/or A.8.

4. The facts as alleged in paragraphs B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8 and/or B.9.

FIFTH 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:

5. The facts as alleged in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8., B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8 and/or B.9.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

6. The facts as alleged in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8., B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8 and/or B.9.

DATE: April 17, 2006
Albany, New York

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

APPENDIX II

TERMS OF PROBATION

Dr. Bijoy Sarmaroy's license to practice medicine in the State of New York shall be on probation for a period of one (1) year.

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

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit prompt (within 20 days) written notification to the Board, addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River St., 4th Floor, Troy, New York 12180, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York State shall toll the probationary period, which shall be extended by the length of residency or practice outside New York State.

5. Respondent shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms and conditions of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

6. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

7. Respondent shall enroll in and satisfactorily complete a continuing education program in the area of reading and interpreting radiological tests. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and shall be completed within the year of probation. The Respondent must provide written certification of satisfactory completion of the course and the expense of this course shall be the Respondent's sole responsibility.

8. The Respondent shall submit to the Director of OPMC a list of all hospitals wherein the Respondent has surgical privileges and for each such hospital a written acknowledgement of the terms of probation. If the Respondent obtains surgical privileges at any additional hospitals during the period of probation he shall be required to comply with the same terms noted above.

9. After 30 days from the effective date of this Order the Respondent shall practice medicine only when monitored by a licensed physician, board certified in general surgery, proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the practice 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, but no less than 10%, of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of medical care and in particular whether the Respondent is personally reviewing the radiological tests of his patients and noting this in his medical records. Any refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

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 (18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective of this Order.

10. The Respondent shall comply with all terms, conditions, restrictions limitations and penalties to which he is subject pursuant to this Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against the Respondent as may be authorized pursuant to law.