STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

November 13, 1995

RECEIVED
NOV 13 1995
OFFICE OF MEDICAL CONDUCT

Daniel Guenzburger, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Amy T. Kulb, Esq.
Jacobson and Goldberg
585 Stewart Avenue
Garden City, New York 11530

RE: In the Matter of Rameshwar Pathak, M.D.

Effective Date: 11/20/95

Dear Mr. Guenzburger and Ms. Kulb:

After receiving Mr. Guenzburger's November 3, 1995 letter, announcing that the Petitioner would not perfect their appeal in this case, the Administrative Review Board considers this case withdrawn.

The Hearing Committee's Determination shall be effective upon the parties' receipt of this letter.

Sincerely,

James F. Horan
Administrative Law Judge

NEW YORK STATE DEPARTMENT OF HEALTH 19

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

IN THE MATTER

OF

RAMESHWAR PATHAK, M.D.

ADMINISTRATIVE
REVIEW BOARD
ARB NO. 95-195

By notice dated September 5, 1995, the Petitioner requested an administrative review of the Hearing Committee on Professional Medical Conduct's August 29, 1995 Determination in the case of Dr. Pathak. In a November 3, 1995 letter, the Petitioner has advised the Review Board that they will not perfect the appeal in this case.

At our deliberations on November 10, 1995, the Board reviewed the Respondent's November 3, 1995 letter. The Board now considers the Petitioner's appeal to be withdrawn and the Hearing Committee's Determination to be final.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19
NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF RAMESHWAR PATHAK, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Pathak.

DATED: Albany, New York

11/10 **, 1995**

ROBERT M. BRIBER

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF RAMESHWAR PATHAK, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Pathak.

DATED: Delmar, New York

Nov 10, **1995**

SUMNER SHAPIRO

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF RAMESHWAR PATHAK, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Pathak.

DATED: Brooklyn, New York
11/10/95, **1995**

WINSTON S. PRICE, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF RAMESHWAR PATHAK, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Pathak.

DATED: Roslyn, New York
Nov 10, **1995**

EDWARD C. SINNOTT, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

IN THE MATTER OF RAMESHWAR PATHAK, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Pathak.

DATED: Syracuse, New York
10 Nov , **1995**

William A. Stewart

WILLIAM A. STEWART, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

August 29, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Amy T. Kulb, Esq.
Jacobson and Goldberg
585 Stewart Avenue
Garden City, New York 11530

Rameshwar Pathak, M.D.
630 Montauk Highway
Shirley, New York 11967

RECEIVED
AUG 30 1995
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

RE: In the Matter of Rameshwar Pathak, M.D.

Dear Mr. Guenzburger, Dr. Pathak and Ms. Kulb:

Enclosed please find the Determination and Order (No. 95-195) 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 if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

NEW YORK STATE DEPARTMENT OF HEALTH 19

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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), 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 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 all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

NEW YORK STATE DEPARTMENT OF HEALTH 19

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

IN THE MATTER	DETERMINATION
OF	AND
RAMESHWAR PATHAK, M.D.	ORDER

BPMC-95-195

A Notice of Hearing and Statement of Charges, both dated April 5, 1995, were served upon the Respondent, Rameshwar Pathak, M.D. **THEA GRAVES PELLMAN (Chair), F. MICHAEL JACOBIUS, M.D., and JOHN H. MORTON, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Daniel Guenzburger, Esq., Assistant Counsel. The Respondent appeared by Jacobson and Goldberg, Amy T. Kulb, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	April 20, 1995
Answer to Statement of Charges:	None
Date of Amended Statement of Charges:	June 5, 1995
Pre-Hearing Conference:	May 1, 1995
Dates of Hearings:	June 5, 1995 June 19, 1995 July 11, 1995

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Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 31, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 28, 1995
Witnesses for Department of Health:	Mark B. Schiffer, M.D.
Witnesses for Respondent:	Arnold R. Conrad, M.D. Rameshwar Pathak, M.D.
Deliberations Held:	August 7, 1995

STATEMENT OF CASE

Respondent is a cardiologist practicing on Long Island. The Department has charged Respondent with four specifications of professional misconduct based upon his medical care and treatment of three patients. A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I. Hearings were held in this matter before a three-member Committee on Professional Conduct.[1]

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in

[1]All members of the Hearing Committee were present at all hearing dates, with the exception of July 11, 1995. Ms. Pellman was not present at that session. By execution of this Determination and Order Ms. Pellman certifies that she has read the complete record of the proceedings, including the transcript of the July 11, 1995 hearing.

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arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Rameshwar Pathak, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State by the issuance of license number 153924 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through December 31, 1996 from 630 Montauk Highway, Shirley, New York 11967. Respondent specializes in cardiology, but does not hold board certification in the specialty. (145, 222; Pet. Ex. #2).

Patient A

2. On or about April 22, 1992, Respondent treated Patient A at his office located in a clinic in Hollis, New York. Patient A, a nine year-old boy, had been referred to Respondent by a pediatrician, Dr. Caramihai, to rule out a mitral valve prolapse. A mitral valve prolapse occurs when the mitral valve leaflets are thickened, stretched, have extra tissue or some other problem which causes the valve leaflets to prolapse or bend backwards toward the left atrium. The condition is fairly common and is considered to be a normal variant rather than a disease. (28, 145).

3. Patient A reported a single incident of near fainting and heart palpitations which occurred after exercising in gym class. He also complained of severe headaches twice a day for the past two months. (Pet. Ex. #11).

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4. Respondent testified that Patient A's most significant item of medical history was severe headaches for the past two months. In spite of the importance Respondent attributed to the symptom, neither he nor the pediatrician performed a neurological examination. Respondent conceded that he should have performed such an examination. (153, 186).

5. Respondent noted a grade one to two over six mid-systolic murmur. The finding is not typical for mitral valve prolapse. The classical physical finding for mitral valve prolapse is a mid-systolic click. (27, 294; Pet. Ex. #3).

6. Respondent ordered M mode and 2D echocardiography to rule out a mitral valve prolapse. Echocardiography utilizes sound waves to create an image of the heart and its structure which can be seen on a screen and recorded on videotape and paper. The test enables the physician to observe relationships between cardiac structures and to measure the size of these structures. (29).

7. Mark Schiffer, M.D., the Petitioner's expert, did not identify a mitral valve prolapse on the videotape of Patient A's echocardiogram. Both Dr. Schiffer and Respondent's expert, Arnold Conrad, M.D., consider the identification of a mitral valve prolapse on an echocardiogram to be very subjective. However, Dr. Conrad stated that the echocardiogram for Patient A showed a borderline mitral valve prolapse. Although Dr. Conrad observed a little bend in the mitral valve that might suggest a prolapse, he testified that the prolapse was "not something that would hit you in the face... and certainly was not a marked

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mitral valve prolapse..." Contrary to the opinions of both Petitioner's and Respondent's expert witnesses, Respondent testified that he was quite confident that he had identified a mitral valve prolapse. (37, 191, 286, 295).

8. Respondent inappropriately diagnosed mitral valve prolapse by failing to order a Doppler evaluation and color flow study. The Doppler evaluation and color flow study uses sound waves to evaluate the velocity and direction of the blood flow. The test provides information about mitral regurgitation and mitral valve insufficiency that could not be obtained from an echocardiogram. The Doppler is an essential part of a complete examination of a patient with valvular heart disease, and is especially important in identifying congenital heart defects in children. (29, 289).

9. Respondent deviated from accepted medical recordkeeping standards by failing to note cardiac measurements from the echocardiographic study. The report of an echocardiogram should include abnormal findings and a series of standard measurements, including the dimensions of the ventricles, left atrium, the thickness of the walls of the left ventricle, and descriptions of the motion of the individual valves. The purpose of maintaining such a record is to establish a baseline for comparison with later echocardiographic studies. Respondent conceded that he should have made a written report of the echocardiographic study. (31, 176; Pet. Ex. #3).

10. Respondent failed to order an electrocardiogram ("EKG") to rule out congenital heart disease and abnormal cardiac

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rhythm. An electrocardiogram is a test which measures electrical impulses from the heart. The test is used to analyze cardiac rhythm and obtain information about chamber enlargement and thickening of the heart. (32-33).

11. Contrary to Respondent's assertion that an EKG would not help in diagnosing a congenital heart defect, Respondent's expert, Dr. Conrad, conceded that the test would aid in making such a diagnosis. (166, 293).

12. Respondent incorrectly asserted that he could adequately evaluate the patient for a cardiac rhythm abnormality by the performance of a physical examination and echocardiogram. However, Dr. Conrad pointed out that the echocardiogram and physical examination could not pick up certain rhythm abnormalities, such as a junctional rhythm, which could have been identified with an EKG. (165, 291).

13. Respondent didn't order Holter monitoring for a 24 hour period. The Holter monitor is a device that records the cardiac rhythm over a period of time. If the patient experienced palpitations while wearing the monitor, it could provide useful information for detecting the cause of the palpitations. The test is a standard procedure followed when a patient complains of fainting or heart palpitations. Respondent's expert testified that although the test was not "one hundred percent necessary", a Holter monitor could be helpful. (33, 50, 281).

14. Respondent's prescription of Tenormin, based on an isolated instance of heart palpitations, was inappropriate. Tenormin is the brand name for a long-acting beta blocker. Beta

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blockers are a class of drugs that antagonize the effects of adrenaline and are generally prescribed for high blood pressure, various cardiac arrhythmias, angina, as well as a variety of non-cardiac conditions, such as migraine. The common side-effects of beta blockers include lethargy, fatigue, sleep disturbance and depression. These side effects are especially pronounced in children. Respondent inappropriately prescribed the medication because he lacked sufficient information upon which to concluded that the patient's symptoms were caused by a mitral valve prolapse, and he lacked a diagnosis of a specific cardiac arrhythmia for which the medication might have been indicated. Respondent also failed to adequately explore alternative explanations for Patient A's episode of near fainting and palpitations. Patient A's history of a low hematocrit and the complaint of severe headaches suggested other avenues for exploration. Finally, the prescription of Tenormin was inappropriate because Respondent should have performed an EKG to rule out a possible cardiac rhythm disturbance prior to prescribing the medication. (36-37, 53-54).

15. Respondent failed to note in Patient A's medical record the fact that he prescribed Tenormin for a 90 day period. The duration of treatment should have been noted, if, as Respondent testified, he only intended to prescribe the medication for a limited time. Respondent conceded that he should have recorded a more detailed treatment plan. (35, 171, 176; Pet. Ex. #4).

16. Respondent failed to order a follow-up visit. Such

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a visit should have been ordered to monitor the effects of the medication and to determine whether continuing the treatment was appropriate. (38).

Patient B

18. On or about and between February 28 and March 8, 1992, Patient B, an 86 year-old male, was treated for an acute myocardial infarction at Central Suffolk Hospital. Respondent's treatment of Patient B was limited to interpreting electrocardiograms performed at various times during the hospitalization. Respondent served on a panel of physicians at Central Suffolk Hospital, primarily cardiologists, who reviewed EKGs that had been previously interpreted by attending and other treating physicians. The purpose of this procedure is to ensure a uniform high level of accuracy in the interpretations of EKGs at the hospital. The interpretation rendered by the reviewing cardiac specialist was the official hospital interpretation of the EKG. (62, 98; Pet. Ex. #8).

19. On or about February 29, 1992, Respondent interpreted EKGs for Patient B performed on February 28, 1992 at 6:41 P.M. and February 29, 1992 at 7:41 A.M., respectively. (Pet. Ex. #8).

20. On the interpretive report for the February 28, 1992 EKG, Respondent noted improved ST elevation in the inferior wall since February 28, 1992, lateral wall ischemia improved since February 28, 1992. Respondent also indicated that Patient B had a normal sinus rhythm. (35-37; Pet. Ex. #8).

21. On the interpretative report for the February 29,

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1992 EKG, Respondent noted acute inferior wall MI, old anterior wall MI, lateral wall ischemia. He also noted a normal sinus rhythm. (32-34; Pet. Ex. #8).

22. Respondent testified that he inadvertently transposed the interpretations on the two EKGs. Respondent claimed that he noted his interpretation of the February 28, 1992 EKG on the report for February 29, 1992, and that he noted his interpretation of the February 29, 1992 EKG on the report for February 28, 1992. (209).

23. Accepting Respondent's testimony that he transposed the interpretations of the EKGs performed on February 28 and 29, 1992, Respondent still incorrectly interpreted the February 28, 1992 EKG. The correct interpretation for the February 28, 1992 EKG is atrial fibrillation with a moderate ventricular response, right bundle branch block, and ST segment elevations in the inferior leads consistent with an acute injury pattern with ischemic depressions in the lateral limb leads consistent with acute inferior wall myocardial infarction. (63).

24. Respondent made two significant errors in his interpretation of the February 28, 1992 EKG. First, he incorrectly evaluated the cardiac rhythm by diagnosing normal sinus rhythm, rather than atrial fibrillation. Second, Respondent failed to diagnose a right bundle branch block. (66-67; Pet. Ex. #8, p. 32).

25. Accepting Respondent's testimony that he transposed the interpretations of the two EKGs performed on February 28 and 29, 1992, Respondent still incorrectly interpreted the February

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29 EKG. Respondent's errors were similar to those made in his interpretation of the February 28, 1992 EKG, in that he diagnosed normal sinus rhythm rather than atrial fibrillation and he failed to diagnose right bundle branch block. (71-72).

26. Atrial fibrillation occurs when the electrical activity of the heart becomes disorganized and the cardiac rhythm is irregular. The failure to diagnose atrial fibrillation may effect such treatment decisions as whether to administer anti-coagulants or prescribe medication to control a patient's heart rate. (64, 72).

27. The diagnosis of right bundle branch block indicates that the patient has a conduction disturbance which impairs the flow of electrical activity through the right bundle system of the heart. The diagnosis of right bundle branch block in a patient with an acute coronary syndrome is a significant diagnosis that can influence treatment. (71).

28. Respondent inaccurately interpreted an EKG taken on or about March 1, 1992 at 8:02 A.M. Respondent noted an interpretation of normal sinus rhythm, left bundle branch block, with a change from February 29, 1992. The correct interpretation of the EKG was atrial fibrillation, with moderate ventricular response with a right bundle branch block, inferior wall MI versus left anterior hemi block, consistent with an evolving inferior wall MI. As in the first two EKGs, Respondent failed to diagnose atrial fibrillation. Further, Respondent diagnosed a left bundle branch block, when the patient actually had a right bundle branch block. (74; Pet. Ex. #8).

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29. The interpretation of atrial fibrillation and right bundle branch block are relatively basic diagnoses that should be made without difficulty by either a cardiologist or general internist. Respondent's difficulty with these basic EKG interpretations is further evidenced by his diagnosing normal sinus rhythm rather than atrial fibrillation on an EKG he interpreted for Patient C on July 6, 1991. (100-101; Pet. Ex. #9, pp. 9, 36-37).

30. Respondent conceded that he incorrectly interpreted the February 28, 29 and March 1, 1992 EKGs. (216, 224).

31. Respondent claimed that since this incident involving Patient B, he has not been formally criticized for his interpretation of EKGs at Central Suffolk Hospital. However, he acknowledged that the hospital does not subject the EKGs he interprets as a consultant (the vast majority of his interpretations) to quality assurance review. (217, 221).

Patient C

32. On or about July 4, 1991, at 6:04 P.M., Patient C, a 67 year-old diabetic male, presented to the Central Suffolk Hospital emergency room with complaints of substernal chest pain, on and off for a week, two attacks of chest pain on the date of admission, and pain radiating to the left arm. (Pet. Ex. #9).

33. Over an approximately two hour period in the emergency room, the patient received the following medications for chest pain: one dose of sublingual Procardia, three doses of sublingual nitroglycerine, one dose of intravenous nitroglycerin and two doses of intravenous morphine. Despite the large

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quantity of medication, Patient C's chest pain did not abate. At 8:20 P.M., the patient's chest pain was rated as 4, on a scale of 1 to 10. (359-360; Pet. Ex. #9, pp. 65, 90).

34. Respondent was called to evaluate Patient C on or about July 4, 1991, at 8:04 P.M. An emergency room nurse's note indicates that at 8:45 P.M. he was evaluating Patient C. Respondent testified that his evaluation consisted of reviewing the notes of the physician and nurses from the emergency room, taking a history, performing a physical examination and reviewing diagnostic tests. (228-229, 231; Pet. Ex. #9, pp. 65, 90).

35. Patient C had an EKG at 6:20 P.M., sixteen minutes after presentation to the emergency room. A second EKG was performed in the emergency room on or about 7:30 P.M. Respondent claimed that he only reviewed the 6:20 P.M. EKG, and that he was unaware of the second EKG at the time he evaluated Patient C in the emergency room. (234-235; Pet. Ex. #9, pp. 18-20, 23-25).

35. Respondent's claim that he did not see the 7:30 P.M. EKG is not credible. The emergency room nurse's notes indicate that a second EKG was ordered at 7:05 P.M., and another note indicates that at 7:20 P.M. the emergency staff was still awaiting the results of the repeat EKG. The emergency room record, which Respondent acknowledged reviewing, put him on notice of the existence of an additional EKG. In the unlikely event that the second EKG became detached from Patient C's chart, Respondent would have had an obligation to follow-up on the order and locate the tracing. (234, 358; Pet. Ex. #9, p. 92).

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36. Respondent erroneously diagnosed unstable angina as Patient C's admitting diagnosis. Patient C's 6:20 P.M. EKG indicated significant ST elevation in leads V2 and V3, which is a characteristic injury pattern of acute myocardial infarction. Based on the ST segment elevation, the patient's crushing chest pain, and his history of diabetes, Respondent should have diagnosed acute anterior wall myocardial infarction. (23, 109, 235).

37. Respondent inaccurately interpreted the 6:20 P.M. emergency room EKG by neglecting to find that the EKG indicated an injury pattern consistent with an acute MI. Respondent's interpretation was regular sinus rhythm, right bundle branch block, left axis deviation. Although the EKG taken at 6:20 P.M. was not diagnostic of acute MI, it did show a significant ST elevation. However, the ST segment elevation in the 7:30 P.M. EKG was more pronounced. This EKG showed significant ST elevation in the V1, V2 and V3 leads. The increased ST elevation, coupled with continued complaints of chest pain, confirmed the diagnosis of acute myocardial infarction. (110-111, 231; Pet. Ex. #9).

38. Dr. Conrad testified that based upon his review of the record, he would have suspected that Patient C had an acute myocardial infarction in the emergency room. (346).

39. Respondent deviated from accepted medical standards by failing to order thrombolytic therapy immediately after his evaluation of Patient C in the emergency room at or about 8:30 P.M. Thrombolytic therapy was the accepted method of treating an

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acute myocardial infarction in July, 1991. The purpose of thrombolytic therapy is to break up or dissolve the thrombus (clot) that is causing reduced cardiac function. The clinical studies of thrombolytic therapy indicate that the efficacy of the treatment is directly related to how soon the drug is administered after an infarction. (113, 116, 346).

40. According to Dr. Schiffer, Patient C should have received thrombolytic therapy no later than 7:30 P.M., the time of the second emergency room EKG. Since Respondent did not see the patient until approximately 8:30 P.M., he can only be held responsible for the delay in the administration of thrombolytic therapy from the point of his initial evaluation. Patient C did not receive thrombolytic therapy until July 5, 1991, at 12:45 A.M. Thus, thrombolytic therapy was delayed by approximately four hours attributable to Respondent's actions. (114-116).

41. Respondent claimed that he did not diagnose an acute MI because the ST elevation in the 6:20 P.M. and 7:30 P.M. EKGs did not rise above one millimeter or more of elevation in two or more contiguous limb leads or two millimeters or more of elevation in two or more contiguous precordial leads. This defense is not credible. In determining whether the patient has an acute MI, a physician must evaluate the degree of ST elevation on the EKG in conjunction with the patient's entire clinical picture. Significantly, Dr. Conrad testified that he suspected an acute myocardial infarction, even though he endorsed the same criteria for evaluating ST elevation as Respondent. (111, 336-337, 346, 371).

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42. Dr. Conrad criticized Respondent for failing to monitor the patient with frequent repeat EKGs, including a failure to order an EKG when he evaluated the patient in the emergency room. Patient C did not have an electrocardiogram between 7:30 P.M. and 10:45 P.M., a gap of over three hours. (344, 347-348; Pet. Ex. #9, p. 22).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (2);

Paragraph A.1: (10-12);

Paragraph A.3: (14);

Paragraph A.4: (16);

Paragraph A.5: (2-8);

Paragraph A.6: (9, 15);

Paragraph B: (18);

Paragraph B.1: (19-20, 22-24, 30);

Paragraph B.2: (19, 21-22, 24-25, 30);

Paragraph B.3: (28, 30);

Paragraph C: (32);

Paragraph C.1: (34-41);

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Paragraph C.2: (37);

Paragraph C.3: (39-40).

The Hearing Committee further concluded that the following Factual Allegations should not be sustained:

Paragraph A.2;

Paragraph B.4.

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

First Specification: (Paragraphs A, A1, A3, A4, A5, A6, B, B1, B2, B3, C, C1, C2, and C3);

Second Specification: (Paragraphs A, A1, A3, A4, A5, A6, B, B1, B2, B3, C, C1, C2, and C3);

Third Specification: (Paragraphs A and A6).

The Hearing Committee further determined that the follow Specification should not be sustained:

Fourth Specification.

DISCUSSION

Respondent is charged with four specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a February 5, 1992 memorandum prepared by

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Peter J. Millock, Esq., then 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 Hearing 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.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Department has sustained its burden of proof with regard to the First through Third Specifications, but did not prove the Fourth Specification of professional misconduct raised against Respondent. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

The Hearing Committee initially assessed the credibility of the witnesses presented by the parties. The Department presented Mark Schiffer, M.D., a board certified cardiologist. Dr. Schiffer has no demonstrable stake in the outcome of these proceedings and no bias was alleged by Respondent. Dr. Schiffer testified in a clear, straightforward

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manner. The Hearing Committee gave credence to his testimony.

Respondent presented Arnold Conrad, M.D., also a board certified cardiologist. Dr. Conrad's testimony was also direct and concise. Significantly, his opinions, on occasion, differed from those of Respondent and supported the Department's position.

Respondent also testified on his own behalf. He has an obvious stake in the outcome of this case. Moreover, his testimony was contradicted by the experts for both parties, as well as by the documentary evidence. Consequently, the Hearing Committee placed little weight on his testimony.

Patient A

Respondent treated Patient A, a nine year old boy, following a referral by the child's pediatrician. Patient A had reported a single incident of near fainting and heart palpitations after exercising in gym class. He also complained of severe headaches twice a day for two months. The pediatrician sent the patient to Respondent to rule out mitral valve prolapse.

Respondent failed to perform an appropriate work-up of Patient A prior to reaching a diagnosis of mitral valve prolapse. Although he did perform M mode and 2D echocardiography, Respondent neglected to order relevant tests, such as an electrocardiogram, as well as Doppler evaluation and color flow studies. These studies were necessary to rule out congenital heart disease and any cardiac rhythm abnormalities.[2] Respondent

[2]Respondent also failed to order a 24 hour Holter monitor, as alleged by the Department. However, the Hearing Committee concluded that this did not constitute a

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failed to appreciate the significance of performing an EKG for Patient A. Respondent did not order an EKG based on the erroneous assumption that he could adequately evaluate the patient for a cardiac rhythm disturbance by physical examination and review of the echocardiogram. He also erroneously assumed that an EKG would not help in diagnosing a congenital heart defect. Respondent also failed to prepare a written report of the results of the echocardiography studies which he did perform, setting forth his diagnosis and treatment plan.

Respondent also failed to consider other causes for the patient's symptoms. Respondent testified that he considered Patient A's complaint of severe headaches to be the most significant item in his recent history, yet failed to perform a neurological examination.

Given Respondent's inadequate diagnostic work-up, Respondent lacked sufficient information about Patient A to justify treatment with a potent beta-blocker such as Tenormin. Having prescribed Tenormin for the patient, Respondent then failed to order a follow-up visit to monitor the patient's progress with the drug. Respondent argued that he expected the patient's pediatrician to monitor the patient's condition at a previously scheduled visit. However, in the absence of a written consultation report, there is no evidence that the pediatrician was aware that the patient had been placed on Tenormin, nor the

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significant deviation from accepted standards of medical practice. As a result, the Hearing Committee did not sustain Factual Allegation A2.

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intended duration of the treatment.

The Hearing Committee concluded that Respondent's medical care and treatment of Patient A demonstrated both negligence and incompetence, as defined above. In addition, the Committee concluded that Respondent failed to maintain an accurate medical record for the patient, insofar as he failed to record the findings of the echocardiography and a detailed plan of treatment. Therefore, the Committee sustained the Third Specification.

Patient B

Patient B, an 86 year-old male, was treated for an acute myocardial infarction at Central Suffolk Hospital during the period February 28, 1992 through March 8, 1992. Respondent's treatment of Patient B was limited to interpreting EKGs performed at various times during the hospitalization. Respondent served on a panel of physicians who reviewed EKGs that had previously been interpreted by attending and other treating physicians. The interpretations rendered by Respondent constituted the official hospital interpretation of the EKGs in question.

Respondent interpreted EKGs performed on Patient B on February 28, February 29 and March 1, 1992. All three interpretations contain serious errors. Respondent testified that he inadvertently transposed the interpretations of the February 28 and 29, 1992 EKGs. The Hearing Committee accepted Respondent's claim that the reports were transposed. Nevertheless, serious errors remain. In both instances, Respondent incorrectly identified atrial fibrillation as normal

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sinus rhythm. In addition, Respondent failed to identify a right bundle branch block.

Respondent also incorrectly interpreted the March 1, 1992 EKG. Respondent noted a normal sinus rhythm, left bundle branch block, with a change from February 29, 1992. He again missed the patient's atrial fibrillation, and missed the right bundle branch block. He also failed to note that the EKG was consistent with an evolving inferior wall myocardial infarction.

The interpretation of atrial fibrillation and right bundle branch block are relatively basic diagnoses that should be made without difficulty by either a cardiologist or general internist. The failure to correctly interpret the EKGs has the potential to adversely effect the treatment decisions for the patient. The Hearing Committee unanimously concluded that Respondent displayed both negligence and incompetence with regard to his interpretation of Patient B's electrocardiograms.

As noted previously, Respondent's treatment of Patient B was strictly limited to the interpretation of electrocardiograms performed during his hospitalization. The Hearing Committee further concluded that the mere fact that Respondent accidentally transposed interpretative reports for two EKGs, and made erroneous interpretations of the findings, does not constitute a failure to maintain a record which adequately reflected the evaluation and treatment of Patient B. As a result, the Committee did not sustain either Factual Allegation B.4 or the Fourth Specification of charges.

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Patient C

Patient C, a 67 year-old diabetic male, presented to the Central Suffolk Hospital emergency room on July 4, 1991 at 6:04 P.M. The patient complained of substernal chest pain, on and off for a week, two attacks of chest pain that day, and pain radiating to the left arm. During a two hour period, the emergency room staff administered a substantial amount of medication for pain relief, including two intravenous doses of morphine. Nevertheless, the patient's chest pain did not abate.

Respondent was called to evaluate the patient and saw the patient at 8:45 P.M. Respondent testified that his evaluation consisted of reviewing the notes of the physician and nurses from the emergency room, taking a history, performing a physical examination and reviewing diagnostic tests. Two EKGs had been performed in the emergency room - at 6:20 P.M. and at approximately 7:30 P.M. Respondent claimed that he only saw the 6:20 P.M. EKG and that he was unaware of the second EKG at the time he evaluated Patient C in the emergency room.

The hearing committee concluded that Respondent's claim is not credible. The emergency room record clearly placed Respondent on notice that a second EKG had been done. Respondent erroneously diagnosed the patient as having unstable angina, rather than an acute myocardial infarction. Respondent did not properly diagnose the patient's MI until he ordered another EKG approximately three hours later at 10:45 P.M. He subsequently ordered thrombolytic therapy in an attempt to dissolve the clot causing the infarction.

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Respondent claimed that he did not diagnose an MI based upon the earlier EKGs because the ST elevation did not rise above one millimeter or more of elevation in two or more contiguous limb leads, or two millimeters or more of elevation in two or more contiguous precordial leads. The Hearing Committee rejected this defense. In determining whether or not the patient has an acute MI, the physician must evaluate the degree of ST elevation in conjunction with the patient's entire clinical picture. Given the nature and extent of Patient C's chest pain, as well as the fact that repeated doses of nitroglycerin and intravenous morphine had failed to ease the patient's pain, Respondent should have diagnosed the ongoing MI when he initially examined the patient.

Respondent ultimately made the proper diagnosis and instituted thrombolytic therapy. Clinical studies have shown that the efficacy of such treatment is directly related to the timeliness of treatment after an infarction. The Hearing Committee gave credence to Dr. Schiffer's testimony that Respondent should have started the thrombolytic therapy when he saw the patient in the emergency room. Instead, the patient did not receive the therapy until July 5, 1991 at 12:45 A.M. - approximately four hours later.

The Hearing Committee unanimously concluded that Respondent's conduct with regard to Patient C constituted both negligence and incompetence, as defined above. The Hearing Committee further concluded that Respondent's repeated acts of negligence and incompetence with regard to Patients A, B and C

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lead to a finding that the First and Second Specifications of professional misconduct should be sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be suspended for a period of two years. The suspension shall be stayed, and Respondent placed on probation for two years. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein. 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.

Respondent, as a cardiologist, represents the highest level of expertise for the treatment of myocardial infarction and other disorders of the cardiovascular system. He successfully completed a fellowship in cardiology. Consequently, he is held to a higher standard with regard to his specialty than a general practitioner. However, the Hearing Committee found that Respondent demonstrated significant deficiencies in his medical knowledge and judgement. He repeatedly misinterpreted EKGs with relatively basic diagnoses that should be made without difficulty by either a cardiologist or general internist. He inappropriately diagnosed a nine year-old boy with mitral valve

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prolapse and treated him with a potent beta-blocker without performing an appropriate diagnostic work-up. He misdiagnosed Patient C's myocardial infarction, leading to a four hour delay in the institution of thrombolytic therapy.

The Hearing Committee unanimously determined that Respondent should be suspended and placed on probation for a period of time to monitor his ability to conform his medical practice to the standards of the profession. In addition to any other terms of probation, the Committee determined that Respondent's medical practice should be monitored by a board-certified cardiologist, selected by Respondent and acceptable to the Director of the Office of Professional Conduct.

The Hearing Committee considered the Department's request that Respondent be directed to undertake "appropriate" additional training in cardiology. Respondent has already completed a cardiology fellowship and has demonstrated mediocre skills, at best. It is not clear to this Committee what additional training would accomplish. Accordingly, no such re-training as been ordered. Under the totality of the circumstances, the Hearing Committee determined that a stayed suspension, with probation and monitoring, is the most appropriate sanction.

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ORDER

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

1. The First through Third Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. The Fourth Specification of professional misconduct is **NOT SUSTAINED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **SUSPENDED** for a period of **TWO (2) YEARS** commencing on the effective date of this Determination and Order. The suspension shall be **STAYED** and Respondent is hereby placed on probation for a period of two years commencing on the effective date of this Determination and Order. The complete terms of probation are contained in Appendix II which is attached to this Determination and Order and incorporated herein.

DATED: Albany, New York
August 25, **1995**

THEA GRAVES PELLMAN (CHAIR)

F. MICHAEL JACOBIUS, M.D.
JOHN H. MORTON, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

TO: Daniel Guenzburger, Esq.
Assistant Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Rameshwar Pathak, M.D.
630 Montauk Highway
Shirley, New York 11967

Amy T. Kulb, Esq.
Jacobson and Goldberg
585 Stewart Avenue
Garden City, New York 11530

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APPENDIX I

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

IN THE MATTER

OF

RAMESHWAR PATHAK, M.D.

NOTICE

OF

HEARING

CASE BPMC
Petitioner EX 1
FOR ID
IN EVID. 5/1/95
MARGO S. BARBARIA, N.P.
ACCU-SCRIBE REPORTING, INC.

TO: RAMESHWAR PATHAK, M.D.
630 Montauk Highway
Shirley, New York 11967

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 12, 1995, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the

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scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

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DATED: New York, New York
April 5, 1995

Chris Stern Hyman
Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: DANIEL GUENZBURGER
Assistant Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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Pet EXHIBIT 14
DATE: 6-5-95
HELAINE GUGGENHEIM

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

----------X

AMENDED

IN THE MATTER : STATEMENT OF

OF : CHARGES

RAMESHWAR PATHAK, M.D. :

----------X

RAMESHWAR PATHAK, M.D., the Respondent, was authorized to practice medicine in New York State on August 22, 1983, by the issuance of license number 153924 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through June 30, 1996 with a registration address of 630 Montauk Highway, Shirley, New York 11967.

FACTUAL ALLEGATIONS

A. On or about April 22, 1992, the Respondent treated Patient A at his office located at 630 Montauk Highway, Shirley, New York. Patient A, a 9 year old male, reported a single incident of near fainting and heart palpitations which occurred after exercising in gym class. He also complained of severe headaches twice a day for the past month. Respondent noted diagnoses of atypical chest pain, palpitations, heart murmur, and mitral valve prolapse. (Patient A and the other patients in the Statement of Charges are identified in the Appendix).

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During the period of treatment regarding Patient A, Respondent:

1. Failed to order an electrocardiogram.
2. Failed to order holter monitoring for a 24 hour period.
3. Inappropriately prescribed Tenormin.
4. Failed to order a follow-up visit to monitor his treatment of Patient A.
5. Inappropriately diagnosed that Patient A had a mitral valve prolapse.
6. Failed to maintain a record which adequately reflected the evaluation and treatment of Patient A.

B. On or about and between February 28 and March 8, 1992 Patient B, an 86 year old male, was treated for an acute myocardial infarction at the Central Suffolk Hospital emergency room located in Riverhead, Long Island. Respondent's treatment of Patient B was limited to interpreting electrocardiograms performed at various times during the hospitalization. During the period of treatment regarding Patient B, Respondent:

1. Inaccurately interpreted an electrocardiogram taken in the emergency room on or about February 28, 1992 at 6:41 P.M.
2. Inaccurately interpreted an electrocardiogram taken on or about February 29, 1992 at 7:43 A.M.

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3. Inaccurately interpreted an electrocardiogram taken on or about March 1, 1992 at 8:02 A.M.

4. Failed to maintain a record which adequately reflected the evaluation and treatment of Patient B.

C. On or about July 4, 1991, 6:00 P.M. Patient C, an 67 year old male, presented to the Central Suffolk Hospital emergency room with a complaint of chest pains for a week. During the period of treatment regarding Patient C, Respondent:

1. Failed to adequately diagnose Patient C's condition.
2. Inaccurately interpreted Patient C's emergency room admission electrocardiogram.
3. Failed to order thrombolytic therapy immediately after his initial evaluation of Patient C on or about July 4, 1991, 8:30 P.M.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1995), in that Petitioner charges that Respondent committed two or more of the following:

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1. The facts in Paragraphs A and A1, A2, A3, A4, A5, A6; B and B1, B2, and/or B3; and/or C and C1, C2, C3.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1995), in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A and A1, A2, A3, A4, A5, A6; B and B1, B2, B3 and/or B4; and/or C and C1, C2, C3.

THIRD AND FOURTH SPECIFICATIONS

FAILING TO MAINTAIN AN ADEQUATE RECORD

Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

3. The facts in Paragraphs A and A6.

4. The facts in Paragraphs B and B4.

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DATED: June 2, 1995
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

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APPENDIX II

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APPENDIX II
TERMS OF PROBATION

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

3. Dr. Pathak shall submit prompt written notification to the Board addressed to the Director, office of Professional Medical conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Pathak leaves New York to reside or practice outside the State, Dr. Pathak shall notify the Director of the Office of Professional Medical Conduct 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 shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Pathak shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Pathak's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

6. Dr. Pathak shall have quarterly meetings with a monitoring physician who shall review Dr. Pathak's practice. The monitoring physician shall be a board-certified cardiologist. This monitoring physician shall review randomly selected medical records and evaluate whether Dr. Pathak's practice comports with generally accepted standards of medical practice. This monitoring physician shall be selected by Dr. Pathak and is subject to the approval of the Director of the Office of Professional Medical Conduct. Dr. Pathak shall not practice medicine until an acceptable monitoring

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physician is approved by the Director.

7. Dr. Pathak shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

8. Dr. Pathak shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Pathak elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

9. If there is full compliance with every term set forth herein, Dr. Pathak may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such othis proceedings as may be warranted, may be initiated against Dr. Pathak pursuant to New York Public Health Law §230(19) or any other applicable laws.

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