New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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

Patrick F. Carone, M.D., M.P.H.
Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

January 8, 1998

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Ashok Dhabuwala, M.D.
34 Cleveland Avenue
Glen Head, New York 11545

RE: License No. 159041

Dear Dr. Dhabuwala:

Enclosed please find Order #BPMC 98-4 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Anthony Scher, Esq.
The Harwood Building
14 Harwood Court, Suite 512
Scarsdale, New York 10583

Roy Nemerson, Esq.

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

IN THE MATTER OF ASHOK DHABUWALA, M.D.	CONSENT ORDER BPMC #98-4

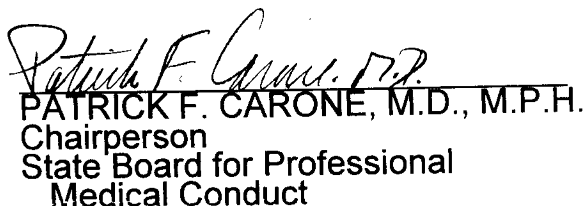
Upon the proposed agreement of ASHOK DHABUWALA, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED.

DATED: 1/3/98



PATRICK F. CARONE, M.D., M.P.H.
Chairperson
State Board for Professional Medical Conduct

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

IN THE MATTER OF ASHOK DHABUWALA, M.D.	CONSENT AGREEMENT AND ORDER UPON REMAND FOR RECONSIDERATION

STATE OF NEW YORK)
ss.:
COUNTY OF)

ASHOK DHABUWALA, M.D., being duly sworn, deposes and says:

That on or about July 9, 1984, I was licensed to practice as a physician in the State of New York, having been issued License No. 159041 by the New York State Education Department.

My current address is 34 Cleveland Avenue, Glen Head, NY, 11545 and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

A Hearing Committee of the State Board for Professional Medical Conduct (Hearing Committee), by Order Number BPMC 93-70 (attached and marked as Exhibit "A"), made certain findings of professional misconduct and imposed a sanction of a two year stayed suspension with a two year period of probation with conditions more fully set forth in Exhibit "A". Such sanction was subsequently modified as a result of further review by the Administrative Review Board of the State Board for Professional Medical Conduct (ARB) and further report of the Hearing Committee (attached and marked as Exhibits "B" through "E"). Such modification was subsequently vacated by order of the Appellate Division of the Supreme Court of the State of New York, Third Judicial Department (attached and marked as Exhibit "F"), with the matter remanded to the ARB for further consideration as to appropriate sanction, not inconsistent with the decision of the Appellate Division.

As I wish to finally dispose of this matter without any further litigation, hearing, argument, and/or review, I hereby make application to the State Board for Professional Medical Conduct for a Consent Order imposing a sanction commensurate with the findings of the Hearing Committee, and appropriate in light of my practice subsequent to such findings, including but not limited to the *defacto* monitoring of my practice by the Office of Professional Medical Conduct.

I hereby request and agree to the following penalty:

> I shall be subject to the sanction imposed by the Original Determination and Order of the Hearing Committee (Exhibit "A") except that the imposed terms of probation shall be modified to include an additional requirement of a pre-operative second opinion of a Board Certified physician, regarding all surgical patients. Both the two year stayed suspension and the two year period of probation shall be deemed to have commenced upon the date of the most recent report of the ARB (Exhibit "E", dated August 21, 1995), and I shall be credited with having been subject to the stayed suspension and having been on active probation during all times since that date. As a result, both periods will be deemed to have been completed.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such

Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. Said Order shall have the same force and effect of an Order entered after hearing pursuant to §230(10) of the N.Y. Public Health Law, or upon the remand ordered by the Court (Exhibit "F".).

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of further litigation, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

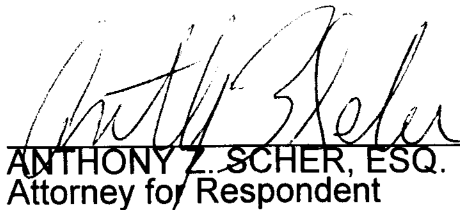
ASHOK DHABUWALA, M.D.
RESPONDENT

Sworn to before me this
22nd day of Dec., 1997

NOTARY PUBLIC
STANLEY D. FRIEDMAN
Notary Public, State of New York
No. 60-4770142
Qualified in Westchester County
Commission Expires Jan 31, 1999

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 12/23/97



ANTHONY Z. SCHER, ESQ.
Attorney for Respondent

DATE: 12/30/97

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

DATE: 12/31/97

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

EXHIBIT "A"

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

IN THE MATTER OF ASHOK DHABUWALA, M.D.	HEARING COMMITTEE DETERMINATION AND ORDER NO. BPMC-93-70

Priscilla R. Leslie, Chairperson, **Stephen A. Gettinger M.D.**, and **Robert J. O'Connor, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Stephen Bermas, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	September 24, 1992
Statement of Charges dated:	September 24, 1992
Hearing Dates:	Oct. 29, Dec. 9, Dec. 10, 1992 March 3, 1993
Deliberation Date:	March 14, 1993

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, New York

Petitioner Appeared By: Peter J. Millock, Esq.
General Counsel
NYS Department of Health
BY: Dawn A. Dweir, Esq.

Respondent Appeared By: Robert S. Asher, Esq.

STATEMENT OF CHARGES

The Statement of Charges have been marked as Petitioner's Exhibit 2 and hereto attached as Appendix A.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of cited evidence.

1. Respondent was authorized to practice medicine in New York State on July 9, 1984 by the issuance of license number 159041 by the New York State Education Department. Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 108-34 47th Avenue, Apt. 2, Corona New York 11368. Ex. 1

PATIENT A

2. Patient A, a 39 year old woman with diabetes and hypertension, was under the treatment of Respondent, a gynecologist, during a period of time which included on or about July 3, 1987 through November 24, 1987. Ex. 4 and 5

3. On July 3, 1987, Patient A presented to Respondent's office at Boro Medical, 32 Fourth Avenue, Brooklyn, NY, complaining of irregular bleeding. Ex. 4

4. Following this visit, on or about July 14, 1987, Respondent had Patient A admitted to Methodist Hospital, 506 Sixth Avenue, Brooklyn, NY, for a total abdominal hysterectomy and left salpingo oophorectomy (TAH LSO). The pathology report from this surgery revealed a normal uterus. Ex. 5

5. A prudent physician would have elicited and documented detailed information relating to prior work-ups. T. 28, 29, 43

6. There is no indication in Respondent's patient chart that all the appropriate information was elicited or documented. Ex. 4

7. Respondent wrote "failed Provera" in his record for Patient A without indicating the course of the Provera, when it was given and the number of months it was given. (Ex. 4) A prudent physician would have included this information in his patient record. T. 32

8. Dr. Josimovich, Director of Obstetrics and Gynecology at Methodist Hospital, called by Respondent as an expert witness, agreed that a prudent physician would have elicited and recorded information relating to a patient's course of attempted hormonal therapy, how long it was undertaken and when it was undertaken. T. 505, 506

9. Respondent failed to record the results of an adequate pelvic examination in view of the fact that he was contemplating major surgery on Patient A. T. 77, 78, 90 A prudent physician would have recorded a statement about the vulva, the vagina, the cervix, the uterus, the ovaries and any other abnormalities that were found in the pelvis. T. 88

10. Dr. Josimovich agreed that Respondent's history and physical examination was incomplete. T. 510, 511

11. Respondent testified that he performed the surgery because of dysfunctional bleeding. T. 415

12. A diagnosis of adenomatous hyperplasia can only be reached by pathological analysis of an endometrial sample. T. 30, 31, 43

13. Respondent entered the diagnosis of adenomatous hyperplasia in his office records without having any pathological analysis to support the diagnosis. Ex. 4 at p. 4, T. 30, 31

14. Respondent produced for the first time at the hearing three pathology reports, 11, 7, and 3 years prior to his performance of the TAH LSO on Patient A. The second D&C showed no evidence of adenomatous hyperplasia. T. 87 There was not corroborative evidence that the patient had hyperplasia. T. 513

15. A prudent physician would not have based his or her decision to perform a hysterectomy on pathological findings from endometrial samplings that were three or more years old since the previous D&C. T. 72

16. Respondent admitted that it is appropriate to have a D&C done if it has been more than 6 months to a year since the previous D&C. T.434

17. Dr. Josimovich agreed that it would have been prudent to perform an endometrial sampling within six months to a year

prior to the surgery, not three years as was the case here. T. 494 - 495, 497

18. Respondent failed to attempt to control Patient A's uterine bleeding with hormonal control prior to subjecting her to a TAH LSO. A prudent physician would have attempted initially to control the patient's dysfunctional bleeding by modes of treatment other than the major surgery involved in a TAH LSO. T. 73

19. Hormonal control through agents other than Provera was available in 1987 to control dysfunctional bleeding in patients including diabetics. T. 35, 36

20. A prudent physician who was attempting to control dysfunctional bleeding through the use of hormones would have evaluated the endometrium before and after such treatment. Respondent never evaluated the endometrium at any point prior to the performance of the TAH LSO. T. 36

21. Dr. Josimovich agreed that if a patient was given a course of hormonal therapy, there should have been an evaluation of the endometrium following that course of hormone therapy. T. 506

22. A prudent physician would not perform a hysterectomy on a patient without medical indication even if the patient

indicated that her economic situation would not allow for an appropriate work-up. T. 66

23. Dr. Josimovich testified that a prudent physician would see that a medically indicated test was done before subjecting a patient to major surgery that might not be indicated. T. 497

24. Respondent did not send the tissue from the hysterectomy for a frozen section. He did not, therefore, know whether or not he was operating on cancer. T. 518

25. Dr. Josimovich had previously evaluated Respondent's performance in this case following an evaluation done by Island Peer Review Organization. T. 497

26. Dr. Josimovich wrote a letter to Island Peer Review Organization in which he stated that he thought that there was a serious deficiency in Respondent's records. T. 520, 521, Ex. 4 at page 18.

27. The pathology report from the TAH LSO performed by Respondent revealed an essentially normal uterus. T. 428, 494

PATIENT B

28. Patient B, a 38 year old woman, was admitted to the gynecology service of Methodist Hospital on or about September 30, 1989 after presenting to the emergency room complaining of pain in her left side and lumps in her abdomen for the past two years. Ex. 6 at p. 7

29. Blood tests performed in the emergency room showed an elevated white blood count and anemia. Ex. 6 at p. 7; T. 93, 94

30. A chest x-ray performed while the patient was in the emergency room revealed left pulmonary infiltrate and left pleural fluid. Ex. 6 at p. 13 A radiologist interpreted the chest x-ray as showing left pulmonary infiltrate and left pleural fluid. Ex. 6 at p. 13 This is the only interpretation of the chest x-ray contained in the patient's chart. Nowhere is it written that the x-ray was interpreted as normal. Ex. 6; Stipulation by Respondent's counsel at T. 551, 208

31. It would have been possible for Respondent to obtain a verbal report from the radiologist at Methodist Hospital regarding his interpretation of the chest x-ray if the written report was not yet available. T. 245

32. Respondent performed a hysterectomy on the patient at 1:00 P.M. two days after she presented to the emergency room on October 2. Ex. 6 at p. 201 Patient B's pulmonary infiltrate was neither evaluated nor treated prior to Respondent performing the surgery. Ex. 6

33. Respondent failed to record a preoperative note containing the results of a history or physical examination of Patient B prior to the performance of the surgery. T. 280, 289; Ex. 6

34. A pulmonologist who evaluated the patient after her surgery elicited a history of a cough three days prior to her admission and a fever. Ex. 6 at p. 54; T. 557 Respondent had failed to elicit any such history from the patient prior to performing the hysterectomy on Patient B. Ex. 6

35. Respondent admitted that to his knowledge no other attending gynecologist at Methodist Hospital examined Patient B prior to his performance of the hysterectomy. T. 295, 296

36. Neither Mohamed Baker, M.D., a limited permittee, who has been repeatedly unable to pass any medical licensing exam, nor Respondent checked with a radiologist for interpretation of Patient B's chest x-ray prior to the performance of the surgery. T. 194, 197, 203, 204, 212.

37. Dr. Josimovich assigned this case to Respondent. Dr. Josimovich knew nothing of the chest x-ray. T. 540, 552, 554, 584

38. Respondent admitted that as operating surgeon it was his responsibility to satisfy himself that the patient was in appropriate condition to undergo surgery before he performed it. T. 291, 292

39. Respondent admitted that he was to blame for not knowing that the patient had pulmonary infiltrate prior to performing the surgery. T. 322

40. Patient B's pulmonary infiltrate as demonstrated on the chest x-ray taken in the emergency room required further evaluation including medical and pulmonary evaluation. T. 95, 96

41. If a prudent physician was aware of pulmonary infiltrate, he/she would have had it evaluated and treated prior to performing a hysterectomy on the patient. T. 118

42. Respondent admitted that there is nothing in the chart which justifies the statement that Patient B's hysterectomy was an emergency. T. 316

43. Nothing in the nurse's notes or any record of phone calls made to doctors indicates that Patient B was having excessive active bleeding. Ex. 6, T. 576, 577

44. A prudent physician would have waited until the underlying pathology of pulmonary infiltrate was under control before performing a hysterectomy. T. 98

45. Respondent made no attempt to control Patient B's bleeding prior to performing the surgery. Respondent agreed that if some alternative method of treatment had worked to stop the bleeding it may have been possible to have corrected the patient's anemia with iron orally and avoid the risk of transfusion. T. 318

46. Respondent agreed that there was a risk of doing a hysterectomy on a patient who might have carcinoma that had not yet been diagnosed. T. 328

47. Respondent agreed that it was wrong to sign Patient B's medical records which indicated that he saw the patient at times that he did not see the patient. T. 299

PATIENT C

48. Patient C, a 47 year old woman, was under the treatment of Respondent during a time which included June 28, 1988 through October 26, 1989. Ex. 7

49. Patient C's presenting symptoms were bleeding and pain. T. 607

50. Following Patient C's first office visit with Respondent at 868 Carroll Street, Brooklyn, New York, on June 28, 1988, Respondent had her admitted to Methodist Hospital where he performed a total abdominal hysterectomy and bilateral salpingo oophorectomy (TAH BSO). Ex. 8

51. Respondent failed to perform and record the results of a proper pre-operative work-up of Patient C's condition before performing the total abdominal hysterectomy and bilateral salpingo oophorectomy. T. 125

52. Dr. Josimovich agreed that a sonogram was indicated for this patient. T. 611 A sonogram performed a couple of years earlier showed a normal uterus. T. 375

53. Dr. Josimovich further agreed that if the diagnosis of fibroid uterus had been ruled out by a sonogram, hormonal therapy of some sort could have been offered such as progestational therapy or low dose estrogen with progestational therapy. T. 612

54. A prudent physician would have performed an evaluation of the endometrium and a pelvic examination that demonstrated pathology before performing a hysterectomy. T. 125

55. The diagnosis of fibroid uterus exists in Respondent's office record, his admission note, operative record and discharge summary. Ex. 7, 8 Respondent's discharge summary was dictated almost three weeks after the operation at a point when the pathology report had revealed that the patient did not have a fibroid uterus. T. 379

56. Patient C did not have a fibroid uterus. T. 609

57. The pathological analysis performed following Patient C's surgery revealed a uterus of normal size. Ex. 8 at p. 24, T. 609.

58. Respondent also included "Rule out endometriosis" in his office record for Patient C. Ex. 7 at p. 4.

59. A prudent physician would try to perform a laparoscopy, not a hysterectomy, to rule out endometriosis. T. 615

60. Dr. Josimovich agreed that there may have been hormonal therapy available to control Patient C's bleeding. T. 604

61. Respondent performed a TAH BSO that was not indicated by the patient's condition, as that condition was known to Respondent. T. 127 Respondent failed to evaluate the endometrium before performing the surgery. T. 125

62. Even if the patient, in fact, insisted that she wanted a hysterectomy and nothing less, a prudent physician would not perform the surgery if he did not believe that the patient's condition warranted the surgery. T. 605

CONCLUSIONS

Each of the parties to this proceeding presented a witness who was accepted as an expert. In each instance, the Committee found that the so-called expert testimony was less convincing and less helpful than it might have been . The expert called by the Petitioner testified to his somewhat limited experience in the matters germane to the charges here presented. The expert called by the Respondent gave the Committee

the impression of being primarily interested in justifying the role of Methodist Hospital. All parties would have been better served by experts with substantial experience on the relevant issues and with no prior involvement in the matters here under consideration.

Respondent is found to have engaged in professional misconduct by reason of practicing medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law sec. 6530(5) (McKinney Supp. 1992) in that:

a. Respondent failed to record in the Methodist Hospital Record the results of an adequate examination of Patient A.

b. Respondent failed to perform a pre-operative endometrial sampling on Patient A.

c. Respondent failed to attempt treatment of Patient A's irregular vaginal bleeding with more conservative methods, i.e., hormonal therapy, before subjecting her to a total abdominal hysterectomy and left salpingo-oophorectomy.

d. Respondent performed a total abdominal hysterectomy and left salpingo-oophorectomy on Patient A despite the fact that it was not indicated by her condition.

e. Respondent failed to have Patient B's underlying pathology of pneumonia under control prior to performing a total abdominal hysterectomy.

f. Respondent failed to perform and record the results of an adequate pre-operative evaluation of Patient B prior to performing a total abdominal hysterectomy.

g. Respondent failed to perform and record the results of a proper pre-operative work-up of Patient C's condition, before performing a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

h. Respondent performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy on Patient C that was not indicated by the patient's condition, as that condition was known to Respondent.

Respondent is found to have engaged in professional misconduct by reason of ordering treatment not warranted by the condition of the patient within the meaning of N.Y. Educ. Law sec. 6530(35) (McKinney Supp. 1992), in that:

a. Respondent performed a total abdominal hysterectomy and left salpingo-oophorectomy on Patient A despite the fact that it was not indicated by her condition.

b. Respondent performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy on Patient C that was not indicated by the patient's condition, as that condition was known to Respondent.

Respondent is found to have engaged in professional misconduct by reason of failing to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient within the meaning of N.Y. Educ. Law sec. 6530(32) (McKinney Supp. 1992), in that:

a. Respondent failed to record in the Methodist Hospital Record the results of an adequate history of Patient A's irregular bleeding, diabetes and hypertension.

b. Respondent failed to record in the Methodist Hospital Record the results of an adequate examination of Patient A.

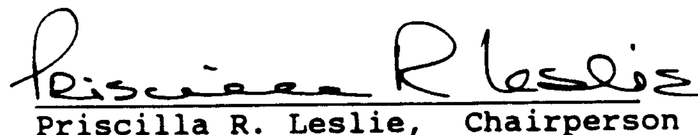
c. Respondent failed to record the results of an adequate pre-operative evaluation of Patient B prior to performing a total abdominal hysterectomy.

d. Respondent failed to record the results of a proper pre-operative work-up of Patient C's condition, before performing a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

ORDER

Although the Respondent must bear full responsibility for the serious charges sustained against him, the Committee recognizes that the conduct of others contributed to the inadequate medical care received by Patients A, B & C. Accordingly, the Committee of the Board for Professional Medical Conduct determines and orders that the Respondent's license to practice medicine be suspended for two years, but that the suspension be stayed and the Respondent be placed on probation for two years. During the probation period, Respondent shall submit quarterly reports to the Office of Professional Medical Conduct for each of his major operative cases to be reviewed for appropriateness of surgical intervention. Such quarterly reports shall include pre-operative diagnosis, post-operative diagnosis, pathology report and all supporting documentation including adequate history and physical examinations used in reaching the decision to perform surgery.

Dated: New York, New York
April 28, 1993



Priscilla R. Leslie, Chairperson

Stephen A. Gettinger
Robert J. O'Connor

APPENDIX I

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

IN THE MATTER	STATEMENT
OF	OF
ASHOK DHABUWALA, M.D.	CHARGES

ASHOK DHABUWALA, M.D., the Respondent, was authorized to practice medicine in New York State on July 9, 1984 by the issuance of license number 159041 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, 1991 through December 31, 1992 from 108-34 47th Avenue, Apt. 2nd, Corona, NY 11368.

FACTUAL ALLEGATIONS

A. Patient A, a 39 year-old woman with diabetes and hypertension, was under the treatment of Respondent, a gynecologist, during a period of time which included on or about July 3, 1987 through November 24, 1987. (Patient A and all other patients are identified in the attached Appendix.) On July 3, 1987 Patient A presented to Respondent's office at Boro Medical, 32 Fourth Avenue, Brooklyn, N.Y., complaining of irregular vaginal bleeding. Following this visit, on or about July 14, 1987, Respondent

had Patient A admitted to Methodist Hospital, 506 Sixth Avenue, Brooklyn, N.Y. for a total abdominal hysterectomy and bilateral salpingo-oophorectomy. The pathology report from this surgery revealed a normal uterus in the correct phase of the ovarian cycle.

1. Respondent failed to perform and record the results of a proper work up of Patient A before performing the total abdominal hysterectomy and bilateral salpingo-oophorectomy.

    a. Respondent failed to perform and record the results of an adequate history of Patient A's irregular bleeding, diabetes and hypertension.

    b. Respondent failed to elicit and record the results of an adequate examination of Patient A including hormonal testing, a sonogram and endometrial sampling.

2. Respondent failed to attempt treatment of Patient A's irregular vaginal bleeding with more conservative methods, i.e., hormonal therapy, before subjecting her to a total

abdominal hysterectomy and bilateral salpingo-oophorectomy.

3. Respondent performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy on Patient A despite the fact that it was not indicated by her condition.

B. Patient B, a 38 year-old woman, was admitted to the gynecology service of Methodist Hospital on or about September 30, 1989 after presenting to the emergency room complaining of pain in the left side and lumps in her abdomen for the past two years. A sonogram revealed an enlarged fibroid uterus. A chest x-ray performed while the patient was in the emergency room revealed a left pulmonary infiltrate and left pleural fluid. Blood tests performed in the emergency room showed an elevated white blood count and anemia. On or about October 2, 1989 Respondent performed an examination under anesthesia, a dilation and curettage and a total abdominal hysterectomy. Following the surgery Patient B was transferred to the medical floor for treatment of her pneumonia.

1. Respondent failed to have Patient B's underlying pathology of pneumonia under control

prior to performing the total abdominal hysterectomy.

2. Respondent failed to control Patient B's anemia prior to performing the total abdominal hysterectomy.

3. Respondent failed to perform and record the results of an adequate pre-operative evaluation of Patient B prior to performing the total abdominal hysterectomy.

C. Patient C, a 47 year-old woman, was under the treatment of Respondent during a time which included June 28, 1988 through through October 26, 1989. Following Patient C's first office visit with Patient C at 868 Carroll Street, Brooklyn, New York, on June 28, 1988, Respondent had her admitted to Methodist Hospital where he performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

1. Respondent failed to perform and record the results of a proper pre-operative work-up of Patient C's condition, before performing a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

2. Respondent performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy that was not indicated by the patient's condition, as that condition was known to Respondent.

3. Respondent made entries in his office record regarding Patient C that he knew to be untrue.

   a. Respondent wrote, "7-8-78 Pt seen today at my M.H. office" despite knowing that this was untrue.

   b. Respondent wrote, "pt insisted that I wants hysterectomy nothing less due to multiple D&C, pelvic pain, pressure symptoms due to possible fibroid uterus & afraid of ovarian cancer" despite knowing that this was untrue.

   c. Respondent wrote, "pt was send for second opinion, nothing help to convince her" despite knowing that this was untrue.

SPECIFICATIONS OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing medicine with gross negligence within the meaning of N.Y. Educ. Law sec. 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

1. The facts in Paragraph A and all the subparagraphs contained therein.

2. The facts in Paragraph B and all the subparagraphs contained therein.

3. The facts in Paragraph C and all the subparagraphs contained therein.

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law sec. 6530(5) (McKinney

Supp. 1992), in that Petitioner charges two or more of the following:

4. The facts in paragraphs A and A1, A.1(a), A.1(b), A.2, A.3; B and B.1, ~~B.2,~~ B.3; and/or C and C.1, C.2, C.3, C.3(a), C.3(b), C.3(c).

FIFTH AND SIXTH SPECIFICATIONS

UNWARRANTED TREATMENT

Respondent is charged with professional misconduct by reason of ordering treatment not warranted by the condition of the patient within the meaning of N.Y. Educ. Law sec. 6530(35) (McKinney Supp. 1992), in that Petitioner charges:

5. The facts in Paragraphs A and A.3.

6. The facts in Paragraphs C and C.2.

SEVENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct by reason of practicing medicine fraudulently within the meaning of N.Y. Educ. Law sec. 6530(2) (McKinney Supp. 1992) in that Petitioner

charges:

7. The facts in paragraphs C and C.3, C.3(a), C.3(b) and C.3(c).

EIGHTH THROUGH TENTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of each patient within the meaning of N.Y. Educ. Law sec. 6530(32) (McKinney Supp. 1992), in that Petitioner charges:

8. The facts in Paragraphs A and A.1, A.1(a), A.1(b).

9. The facts in Paragraphs B and B.3.

10. The facts in Paragraphs C and C.1, C.3, C.3(a), C.3(b), C.3(c).

DATED: New York, New York
September 24, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

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

---X

IN THE MATTER :

OF :

ASHOK DHABUWALA, M.D. :

---X

ADMINISTRATIVE REVIEW BOARD REMAND ORDER
ARB NO.93-70R

The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of **ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on July 30, 1993 to review the Professional Medical Conduct Hearing Committee's (Committee) May 18, 1993 Determination finding Dr. Ashok Dhabuwala guilty of professional misconduct. The Office of Professional Medical Conduct (OPMC) requested the review through a Notice which the Review Board received on June 3, 1993. James F. Horan served as Administrative Officer to the Review Board. Roy Nemerson, Esq. submitted a brief for OPMC on July 3, 1993 and Robert S. Asher, Esq. submitted a response on July 6, 1993.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct charged the Respondent with negligence on more than one occasion, gross negligence, providing treatment not warranted by the patient's condition, practicing the profession fraudulently and maintaining inadequate patient records. The charges arose from the care which the Respondent provided to three patients, A through C.

The Hearing Committee consisted of Priscilla R. Leslie, Chairperson, Stephen A. Gettinger, M.D. and Robert J. O'Connor, M.D. Stephen Bermas, Esq. served as Administrative Officer to the Hearing Committee.

The Hearing Committee sustained the charge that the Respondent was negligent on more than one occasion for his treatment of Patients A, B and C. The Committee sustained the charge that the Respondent ordered treatment not warranted by the patient's condition arising from treatment which the Respondent provided to Patients A and C and the Committee sustained the charge that the Respondent had failed to maintain adequate records for Patients A through C.

The Committee found that the Respondent bore full responsibility for the charges sustained against him, but recognized that others contributed to the inadequate medical care which Patients A, B and C received. The Committee voted to suspend the Respondent's license to practice medicine for two years, but stayed the suspension and placed the Respondent on probation for two years. The Committee required that during the probation period, the Respondent submit quarterly reports to the OPMC for each of his major operative cases, to be reviewed for appropriateness of surgical intervention.

REQUESTS FOR REVIEW

The OPMC has requested that the Review Board modify the Hearing Committee's terms of probation to require that the Respondent must obtain a concurring but independent second opinion from a suitably board certified physician before the Respondent can perform a hysterectomy. The OPMC contends that the probation currently would allow the OPMC to identify inappropriate

hysterectomies only after the surgery was performed. The OPMC contends that adequate public protection would require that an effort be made to prevent such inappropriate procedures.

The Respondent concurs in OPMC's recommendation and has provided OPMC with the name of a Board Certified Gynecologist for approval to provide second opinions in cases in which Dr. Dhabuwala would perform hysterectomies.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board finds that we are unable to complete our review in this case, because the Hearing Committee's Determination does not provide sufficient information to explain how the Hearing Committee arrived at their penalty or why the Committee feels the penalty is sufficient to protect the public. The Review Board votes unanimously to remand this case to the Hearing Committee so that the Committee can issue a Supplemental Determination, in which the Committee should detail the reasons why they feel their penalty is appropriate and in which the Hearing Committee should answer the specific questions which the Review Board pose below. At the time the Hearing Committee issues their Supplemental Determination, the Committee shall provide copies to both parties. The parties will have thirty days from the receipt of the Supplemental Determination to file supplemental briefs with the Review Board.

The Review Board requests that the Hearing Committee address the following questions in their Supplemental Determination:

1. What were the Committee's conclusions regarding the charges of gross negligence and practicing the profession fraudulently?

2. What conduct of others does the Committee feel contributed to the inadequate medical care provided to Patients A, B and C?

3. Why does the Committee limit the review of the Respondent's major operative cases to a two year period?

4. Does the Committee feel that the Respondent's negligence was the result of poor judgement, poor surgical skills or both?

5. Is the Respondent competent to continue practicing surgery?

6. Does the Respondent have sufficient knowledge to make the proper judgments in practicing surgery?

7. Is record review intended as remediation for the Respondent?

8. Is the record review alone enough to correct the deficiencies in the Respondent's practice?

9. Did the Committee consider sending the Respondent for an evaluation of his skills as a physician?

The penalty which the Hearing Committee imposed in this case will remain stayed during the remand period and will continue

stayed until the Review Board issues our final Determination. If the Hearing Committee has any questions concerning this remand, they may communicate the questions to the Review Board in writing through a letter from their Administrative Officer Mr. Bermas to our Administrative Officer Mr. Horan. The parties should receive copies of any such correspondence. The Hearing Committee's Supplemental Determination should be signed by the Hearing Committee's Chairperson. The Review Board will not place any limit on the time which the Hearing Committee will have to issue their Supplemental Determination.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Administrative Review Board remands this case to the Hearing Committee, and instructs the Hearing Committee to issue a Supplemental Determination, which will explain in greater detail the Hearing Committee's reasons for selecting the penalty which the Committee imposed against Dr. Dhabuwala in the Hearing Committee's May 18, 1993 Determination and Order.

2. The penalty against Dr. Dhabuwala shall remain stayed until the Review Board reaches our final Determination in this case.

ROBERT M. BRIBER

WINSTON S. PRICE, M.D.

MARYCLAIRE B. SHERWIN

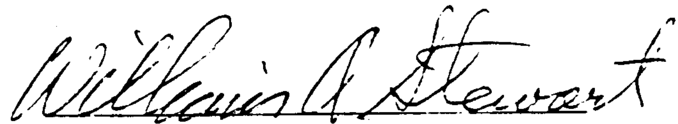
EDWARD C. SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF ASHOK DHABUWALA, M.D.

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

DATED: Syracuse, New York
September 7, 1993

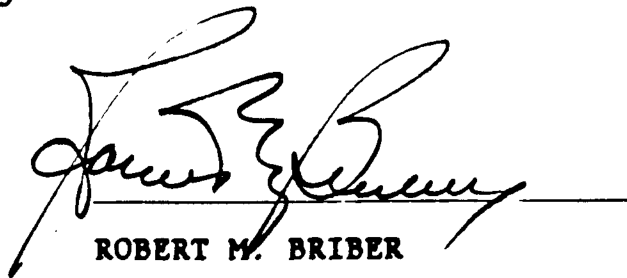


WILLIAM A. STEWART, M.D.

IN THE MATTER OF ASHOK DHABUWALA, M.D.

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

DATED: Albany, New York
September 9, 1993

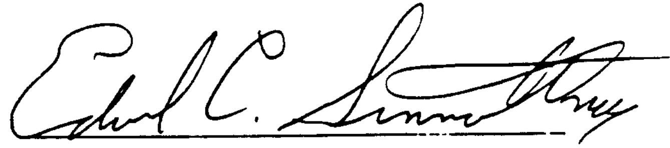


ROBERT M. BRIBER

IN THE MATTER OF ASHOK DHABUWALA, M.D.

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

DATED: Roslyn, New York
September 8, 1993

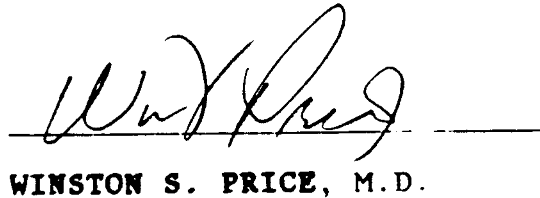


EDWARD C. SINNOTT, M.D.

IN THE MATTER OF ASHOK DHABUWALA, M.D.

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

DATED: Brooklyn, New York
September 12, 1993

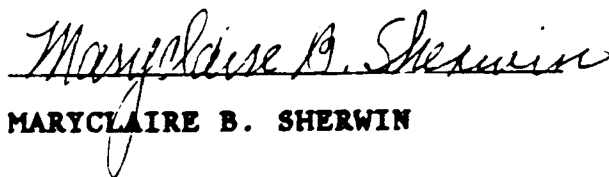


WINSTON S. PRICE, M.D.

IN THE MATTER OF ASHOK DHABUWALA, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Remand Order in the Matter of Dr. Dhabuwala.

DATED: Malone, New York
September 10, 1993



MARYCLAIRE B. SHERWIN

EXHIBIT "C"

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

IN THE MATTER	: **HEARING COMMITTEE**
	: **SUPPLEMENTAL**
OF	: **DETERMINATION**
ASHOK DHABUWALA, M.D.	: **AND ORDER**
	BPMC NO. 93-70S

Priscilla R. Leslie, Chairperson, **Stephen A. Gettinger M.D.**, and **Robert J. O'Connor, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Stephen Bermas, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, including the Administration Review Board Reward Order, ARB No. 93-70R, the Hearing Committee submits this Supplemental Determination and Order.

SUMMARY OF THE SUPPLEMENTAL PROCEEDINGS

Deliberation Date: December 3, 1993

The Remand Order of the Administrative Review Board directed that the Hearing Committee issue a Supplemental Determination in

which the Committee should:

(A) detail the reasons why the Committee feels the penalty set forth in the Committee's Determination and Order is appropriate, and

(B) answer the specific questions posed by the Review Board.

(A) Appropriateness of Penalty

The Hearing Committee concluded after considering all of the credible evidence that the Respondent's cognitive skills were adequate. Respondent's surgical skills were never questioned by the Petitioner.

All of Respondent's inappropriate treatment was in response to requests or demands from his Supervisory Physician and/or his patients. He used poor judgment in responding to these requests or demands.

The Hearing Committee further concluded from the credible evidence that the Respondent's judgment now and in the future would be better and appropriate as a result of the entire hearing process. However, to ensure this and to protect the public, the Committee determined that quarterly reports for two years would confirm its conclusion.

The Hearing Committee would have no objection to the proposed modification of its Determination and Order so as to provide for ongoing supervision of Respondent by another gynecologist, in addition to the quarterly reports, provided the Board-certified supervising physician is approved by the Office of Professional

Medical Conduct.

(B) Specific Questions

1. The Hearing Committee concluded, based upon the credible evidence, that the charges of gross negligence and practicing the profession fraudulently were not sustained.

2. With respect to Patient A, the Respondent used poor judgment in succumbing to Patient A's demand for definitive therapy. An adequate pre-operative work-up was indicated, and alternative methods of therapy may have been available.

With respect to Patient B, the Respondent was assigned this case by Dr. Josimovich, the Director of Ob-Gyn at Methodist Hospital, immediately prior to surgery. Respondent relied on his assumption that the prior medical care given to Patient B was appropriate, but he admitted at the hearing that such reliance was a negligent act. Nonetheless, the credible evidence before the Hearing Committee shows that inadequate medical care had been provided to Patient B before the patient was assigned to Respondent in that:

(a) Patient B's pneumonia was not diagnosed;

(b) Patient B's high fever was not evaluated;

(c) Patient B's anemia was not investigated;

(d) Patient B was assumed to have excessive bleeding when it was not true; and

(e) No pap smear was taken from Patient B before taking her to the operating room in a non-emergency situation.

3. The Hearing Committee determined that two years is an adequate time span to confirm that Respondent's indications for surgery are now appropriate.

4. The Hearing Committee determined that the Respondent's negligence was the result of poor judgment.

5. The Hearing Committee determined that the Respondent is competent to continue practicing surgery.

6. The Hearing Committee determined that the Respondent has sufficient knowledge to make the proper judgments in practicing surgery.

7. The Hearing Committee believes that the hearing process and the proposed record review will provide remediation, and allow for evaluation, review and confirmation. It would also allow for review of records to affirm that there has been an improvement in the quality of Respondent's record-keeping.

8. See answer to No. 7.

9. The Hearing Committee considered sending the Respondent for an evaluation of his skills as a physician, but the Committee believes his negligence was based upon poor judgment rather than lack of skills. The Committee further believes that this poor judgment of Respondent has been improved by Respondent having gone through the hearing process.

Dated: New York, New York
January 3 , 1994

Priscilla R. Leslie, Chairperson

Stephen A. Gettinger, M.D.
Robert J. O'Connor, M.D.

EXHIBIT "D"

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

---X

IN THE MATTER OF ASHOK DHABUWALA, M.D.	ADMINISTRATIVE REVIEW BOARD DETERMINATION AND ORDER ARB No. 93-70

---X

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.[1] and WILLIAM A. STEWART, M.D.[2] held deliberations on March 4, 1994 and April 5, 1994 to review the Professional Medical Conduct Hearing Committee's (Committee) January 10, 1993 Supplemental Determination in the case of Dr. Ashok Dhabuwala. The Review Board remanded the case to the Hearing Committee on October 6, 1993 so the Hearing Committee could issue a Supplemental Determination explaining the reasons for the penalty which the Hearing Committee had imposed in the initial determination in Dr. Dhabuwala's case on May 18, 1993. James F. Horan served as Administrative Officer to the Review Board. Dr. Dhabuwala submitted a letter to the Review Board concerning the penalty on March 9, 1994.

[1]Drs. Sinnott, Price and Stewart participated in the March 4, 1994 Deliberations by telephone.

[2]Drs. Sinnott and Stewart participated in the April 5, 1994 deliberations by telephone.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration. The Review Board exercised its authority to remand in this proceeding.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct (Petitioner) charged the Respondent with gross negligence, negligence on more than one occasion, providing treatment not warranted by the patient's condition, practicing the profession fraudulently and maintaining inadequate patient records. The charges arose from the care which the Respondent provided to three patients, A through C.

The Hearing Committee sustained the charge that the Respondent was negligent on more than one occasion for his

treatment of Patients A, B and C. The Committee sustained the charge that the Respondent ordered treatment not warranted by the patient's condition arising from treatment which the Respondent provided to Patients A and C and the Committee sustained the charge that the Respondent had failed to maintain adequate records for Patients A through C.

The Committee voted to suspend the Respondent's license to practice medicine for two years, but stayed the suspension and placed the Respondent on probation for two years. The Committee required that during the probation period, the Respondent submit quarterly reports to the OPMC for each of his major operative cases, to be reviewed for appropriateness of surgical intervention.

REQUESTS FOR REVIEW

Following the Original Hearing Committee Determination the Petitioner filed a Notice of Review with the Board. The Petitioner submitted a brief on July 3, 1993 requesting the Review Board modify the Hearing Committee's terms of probation to require that the Respondent must obtain a concurring but independent second opinion from a suitably board certified physician before the Respondent can perform a hysterectomy. The Petitioner contended that the Hearing Committee's penalty would have allowed the Petitioner to identify inappropriate hysterectomies only after the surgery was performed. The Petitioner contended that adequate public protection would require that an effort be made to prevent such inappropriate procedures. By letter dated July 6, 1993 the Respondent concurred in OPMC's recommendation and provided the

Petitioner with the name of a Board Certified Gynecologist for approval to provide second opinions in cases in which Dr. Dhabuwala would perform hysterectomies.

REVIEW BOARD REMAND ORDER

On October 6, 1993 the Review Board remanded the case to the Hearing Committee. The Board found that we were unable to complete its review because the Hearing Committee's Determination did not provide sufficient information to explain how the Hearing Committee arrived at their penalty or why the Committee felt the penalty is sufficient to protect the public. The review Board directed the Hearing Committee address the following questions in their Supplemental Determination:

1. What were the Committee's conclusions regarding the charges of gross negligence and practicing the profession fraudulently?

2. What conduct of others does the Committee feel contributed to the inadequate medical care provided to Patients A, B and C?

3. Why does the Committee limit the review of the Respondent's major operative cases to a two year period?

4. Does the Committee feel that the Respondent's negligence was the result of poor judgement, poor surgical skills or both?

5. Is the Respondent competent to continue practicing surgery?

6. Does the Respondent have sufficient knowledge to

make the proper judgements in practicing surgery?

7. Is the record review intended as remediation for the Respondent?

8. Is the record review alone enough to correct the deficiencies in the Respondent's practice?

9. Did the Committee consider sending the Respondent for an evaluation of his skills as a physician?

Hearing Committee Supplemental Determination

The Hearing Committee issued its Supplemental Determination on January 10, 1994.

The Hearing Committee indicated that after considering all of the credible evidence, they concluded that the Respondent's cognitive skills were adequate and that all Respondent's inappropriate treatment was in response to requests or demands from his Supervisory Physician and/or his patients. The Committee felt he used poor judgement in responding to these requests or demands.

The Hearing Committee concluded that the Respondent's judgement would be better and appropriate as a result of the entire hearing process, but to ensure this and to protect the public, the Committee required the submission of quarterly reports for two years.

The Hearing Committee stated they had no objection to the Petitioner's proposed modification of its Determination and Order so as to provide for ongoing supervision of the Respondent by another gynecologist, in addition to the quarterly reports,

provided the Board-certified supervising physician is approved by the Office of Professional Medical Conduct.

(B) Specific Questions

1. The Hearing Committee concluded, based upon the credible evidence, that the charges of gross negligence and practicing the profession fraudulently were not sustained.

2. With respect to Patient A, the Committee concluded that the Respondent used poor judgement in succumbing to Patient A's demand for definitive therapy. An adequate pre-operative work-up was indicated, and alternative methods of therapy may have been available.

With respect to Patient B, the Committee found that Respondent was assigned this case by Dr. Josimovich, the Director of Ob-Gyn at Methodist Hospital, immediately prior to surgery. Respondent relied on his assumption that the prior medical care given to Patient B was appropriate, but he admitted at the hearing that such reliance was a negligent act. Nonetheless, the Hearing Committee felt that the credible evidence before the Hearing Committee showed that inadequate medical care had been provided to Patient B before the patient was assigned to Respondent in that:

(a) Patient B's pneumonia was not diagnosed;

(b) Patient B's high fever was not evaluated;

(c) Patient B's anemia was not investigated;

(d) Patient B was assumed to have excessive bleeding when it was not true; and

(e) No pap smear was taken from Patient B before taking her to the operating room in a

non-emergency situation.

3. The Hearing Committee determined that two years is an adequate time span to confirm that Respondent's indications for surgery are now appropriate.

4. The Hearing Committee determined that the Respondent's negligence was the result of poor judgement.

5. The Hearing Committee determined that the Respondent is competent to continue practicing surgery.

6. The Hearing Committee determined that the Respondent has sufficient knowledge to make the proper judgements in practicing surgery.

7. The Hearing Committee concluded that the hearing process and the proposed record review will provide remediation, and allow for evaluation, review and confirmation. It would also allow for review of records to affirm that there has been an improvement in the quality of Respondent's record-keeping.

8. See answer to No. 7.

9. The Hearing Committee considered sending the Respondent for an evaluation of his skills as a physician, but the Committee believes his negligence was based upon poor judgement rather than lack of skills. The Committee further believes that this poor judgement of Respondent has been improved by Respondent having gone through the hearing process.

Review Board Determination

The Review Board has considered the entire record the Hearing Committee's Supplemental Order and Dr. Dhabuwala's

March 9, 1994 submission.

The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was guilty of negligence on more than one occasion, that the Respondent ordered treatment not warranted by the patient's condition and that the Respondent failed to maintain adequate records. The Review Board finds that the Committee's Determination is consistent with its findings and conclusions.

The Review Board votes to modify the Hearing Committee's Determination, to place Dr. Dhabuwala on probation for two years and to require that the Respondent submit quarterly reports to the Office of Professional Medical Conduct for review. The Review Board does not believe that the Hearing Committee's penalty is consistent with the findings against the Respondent of negligence on more that one occasion and ordering treatment not warranted by the patient's condition. The Review Board does not believe that the penalty is appropriate because the quarterly reports will not provide sufficient protection to the public, the quarterly reports will not provide adequate supervision of the Respondent and the quarterly reports will provide no remediation.

The Hearing Committee stated in their Supplemental Determination that the Respondent committed negligence and ordered excessive treatment as a result of poor judgement and not a lack of skills as a surgeon. The Review Board is concerned that the Respondent's poor judgement may be the result of poor cognitive skills and that the Respondents negligence and ordering of excessive treatment may indicate a lack of basic knowledge necessary to practice medicine. The Review Board believes, that

in order to protect the public, it is necessary to assure that the Respondent's past misconduct is not the result of poor cognitive skills or a lack of knowledge necessary to practice medicine.

The Review Board modifies the Hearing Committee's penalty and orders that the Respondent undergo an evaluation of his knowledge as a physician by completing Phase I of the Physician Prescribed Education Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center Syracuse.[3] The Respondent shall be on probation until he completes the evaluation, except that, if the Respondent has not made arrangements to undergo the PPEP evaluation within thirty days from the effective date of this Determination, the Respondent shall be on suspension until he completes such arrangements. The PPEP Director shall provide copies of Dr. Dhabuwala's evaluation to the Review Board and to the parties.

If the PPEP evaluation determines that the Respondent possesses the requisite knowledge to safely and effectively practice medicine, then the Respondent shall be on probation for a period of two years. The conditions of probation shall include the requirement that the Respondent submit quarterly reports to the Office of Professional Medical Conduct for each of the operative cases, to be reviewed for the appropriateness of surgical intervention. In addition, the Respondent shall not perform a hysterectomy, unless he obtains a concurring but

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[3]Department of Family Medicine, 479 Irving Avenue, No. 200, Syracuse, New York 13210

independent second opinion from a physician who is approved by the Office of Professional Medical Conduct.

In the event that the PPEP evaluation determines that Dr. Dhabuwala does not possess the requisite knowledge to practice medicine safely and effectively, then the matter shall be returned to the Review Board for a further deliberation on the appropriate penalty to assess in that case. If the matter is returned to the Review Board, then each party shall have thirty days from the receipt of the PPEP evaluation to provide comments to the Review Board on what penalty the parties feel that the Review Board should impose in that case.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The July 30, 1993, Determination by the Hearing Committee on Professional Medical Conduct, finding Dr. Ashok Dhabuwala guilty of professional misconduct, is sustained.

2. The Hearing Committee's Penalty placing the Respondent on two years probation is modified.

3. The Respondent shall undergo an evaluation of his knowledge as a physician at the Physician Prescribed Education Program in Syracuse, New York.

4. If the Respondent's evaluation indicates he possesses the skills and knowledge necessary to practice medicine safety and effectively in New York State, he shall be on probation

for two years, subject to the terms noted in this decision.

5. If the evaluation determines that the Respondent does not possess the requisite knowledge to practice medicine safely and effectively in New York State, then the matter shall return to the Review Board for further review as discussed in the Determination.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

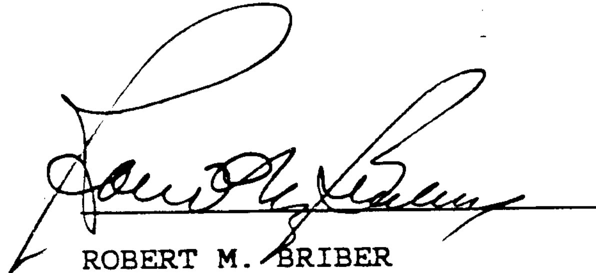
WILLIAM B. STEWART, M.D.

IN THE MATTER OF

Ashok Dhabuwala, 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 Ashok Dhabuwala, M.D..

DATED: Albany, New York
June 24, 1994



ROBERT M. BRIBER

IN THE MATTER OF

Ashok Dhabuwala, 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 Ashok Dhabuwala, M.D..

DATED: Brooklyn, New York

, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF

Ashok Dhabuwala, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Ashok Dhabuwala, M.D..

DATED: Albany, New York

, 1994

Maryclaire B. Sherwin

MARYCLAIRE B. SHERWIN

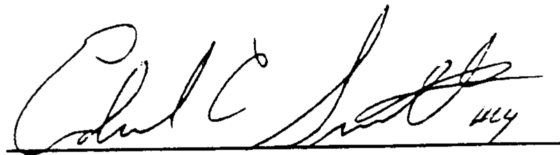
IN THE MATTER OF

Ashok Dhabuwala, 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 Ashok Dhabuwala, M.D..

DATED: Albany, New York

June 24, 1994



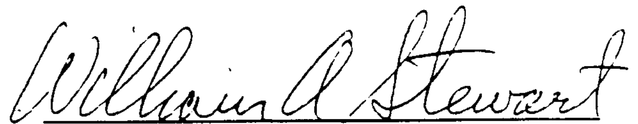
EDWARD C. SINNOTT, M.D.

IN THE MATTER OF

Ashok Dhabuwala, 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 Ashok Dhabuwala, M.D..

DATED: **Albany, New York**
24 June , **1994**



WILLIAM A. STEWART, M.D.

Exhibit E

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

IN THE MATTER OF ASHOK DHABUWALA	ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 93-70

NEW YORK STATE DEPARTMENT OF HEALTH 19

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on August 3, 1995 to determine what action to take in regard to the penalty against Dr. Ashok Dhabuwala (Respondent), following a December 20, 1994 Evaluation on the Respondent by the Physician Prescribed Education Program (PPEP) in Syracuse. By Determination No. 93-70, the Review Board ordered the Respondent to undergo the PPEP Evaluation to determine whether the Respondent possesses the requisite knowledge to practice medicine safely and effectively. By a further Order on May 5, 1995, the Review Board advised the parties that they had thirty days to submit comments, concerning the PPEP Evaluation, to the Review Board for our consideration. Roy Nemerson, Esq. submitted comments for the Petitioner on June 6, 1994 and Robert S. Asher, Esq. submitted comments for the Respondent in June 23, 1995.

THE CASE TO THIS POINT

A Hearing Committee from the Board for Professional Medical Conduct (Hearing Committee) rendered an Initial Determination on May 12, 1993 finding the Respondent guilty of professional misconduct in the treatment of three patients, A through C. The Committee found that the Respondent was guilty of negligence on more than one occasion in the treatment of all three patients, that he had

[1]Dr. Winston Price was unable to participate in the deliberations.

ordered treatment not warranted by the conditions of Patient A and C and that the Respondent had failed to maintain adequate records for Patients A through C. The Committee suspended the Respondent's license for two years, stayed the suspension and placed the Respondent on probation. The probation terms included a requirement that the Respondent submit quarterly reports to the Petitioner for each major operative case for review on whether the surgical intervention was appropriate. The Petitioner then requested an administrative review and asked the Board to require that the Respondent must obtain a concurring but independent second opinion before performing a hysterectomy. The Respondent concurred in the recommendation.

Following initial deliberations, the Review Board remanded this case to the Hearing Committee on October 6, 1993 because the Board felt that we needed additional information about how the Committee had reached their findings and conclusions and how the Committee had come to their Determination on the penalty. On January 10, 1994, the Committee rendered a Supplemental Determination which answered nine specific questions from the Board's Remand Order. The Review Board then rendered our Determination 93-70 which sustained the Hearing Committee's Determination on the charges, but modified the Hearing Committee's penalty, because the Board felt that the penalty was not consistent with findings of negligence in more than one occasion and ordering of unwarranted treatment, because the penalty would not provide adequate supervision of the Respondent and because the penalty would not provide remediation. The Board voted to refer the Respondent for the Phase I Evaluation at PPEP, to determine whether the Respondent possesses the requisite knowledge to safely and effectively practice medicine. The Review Board provided that if the PPEP Evaluation found the Respondent did possess sufficient knowledge, then he would be on probation for an additional two years. The Board provided that if the PPEP Evaluation determined that the Respondent did not possess sufficient knowledge, that the matter would be returned to the Board for a further deliberation on the appropriate penalty.

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THE PPEP EVALUATION

The PPEP Evaluation stated that the findings were not definitive enough to make the decision which the Board had requested "without bias". The Evaluation stated that the Respondent functions well in areas, but that there were other areas of medicine in which the Respondent could improve his skills. The Evaluation suggested that the Respondent would benefit from a structured educational program, but, that such a program was not an option under the Board's Order. The PPE Program returned the matter to the Review Board for further consideration. Upon receiving the Evaluation, the Board then asked the parties for their comments and recommendations, based upon the Evaluation.

THE PARTY'S RECOMMENDATION

The Petitioner has recommended that the Review Board revoke the Respondent's license to practice medicine in New York State. The Petitioner argues that the PPEP Evaluation offered the Respondent an opportunity to demonstrate that he possessed the requisite knowledge to safely and effectively practice medicine, and, that the Respondent has failed to demonstrate persuasively that he can practice safely and effectively. The Petitioner asks that, if the Review Board does not revoke the Respondent's license, that the board impose a sanction that will provide the greatest assurance that such misconduct will not recur.

The Respondent argues that there has been no finding by PPEP that Dr. Dhabuwala can not practice medicine safely and effectively. Further, the Respondent argues that the Respondent has undergone monitoring for nine months and has practiced safely and competently, without a single instance in which his judgement in any other practice area has come under question. The Respondent argues that the vast majority of the PPEP Evaluation was favorable. The Respondent contends that in the absence of a finding that the Respondent can not practice medicine safely and effectively, this matter should not be returned to the Review Board and that the Respondent should be allowed to complete his current probation. The Respondent also questioned the validity of the PPEP Evaluation process.

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THE REVIEW BOARD'S DETERMINATION

The Review Board referred this matter for a PPEP Evaluation for one reason: to determine whether the Respondent is able to practice medicine safely and effectively. The PPEP Evaluation has not given the Board such an assurance. The Board asked for this Evaluation due to our misgivings about the Respondent's judgement. In the absence of an assurance that the Respondent can practice safely and effectively, the Review Board now must again review the Hearing Committee's Determination, to find the appropriate sanction for a physician whose judgement resulted in negligent care and who subjected patients to unwarranted procedures.

The Review Board agrees with the Hearing Committee that the Respondent's poor judgement will not improve through education. The Review Board finds that the way to assure that the Respondent's poor judgement will not result in further negligent conduct or unnecessary medical procedures is to assure that the Respondent remains in a setting in which he will be subject to supervision and his work will be subject to review.

The Review Board concludes that the Respondent should remain on probation for an additional five years, under the same terms as now apply to the Respondent. Those provisions shall include the requirement that the Respondent shall not perform a hysterectomy without an independent second opinion from a physician who has been approved by the Office of Professional Medical Conduct. The Board believes that the latter condition is necessary and appropriate to assure that the Respondent does not perform further unnecessary procedures. We find it necessary to extend the probation because we do not believe two years is a sufficient amount of time to assure that the Respondent's judgement has improved.

The Board also finds that the Respondent should practice only in a supervised setting to assure that there will be ongoing review of the Respondent's work and his judgement. The Board finds that the proper setting to provide such supervision would be in a hospital or other medical facility licensed under Public Health Law Article 28. Such facilities have established lines of supervision and quality assurance programs that will assure continuing oversight of the Respondent's work and the facilities are subject to ongoing inspections by the State and Federal Governments.

NEW YORK STATE DEPARTMENT OF HEALTH

The Board does not believe it is necessary to revoke the Respondent's license in order to protect the public in this case. The Hearing Committee found that the Respondent did not lack the skills to practice surgery. The Committee also found that the patients involved in the Respondent's case received poor care prior to the patients' assignment to the Respondent and the Committee concluded that the Respondent's actions did not amount to gross negligence or fraud in the practice of medicine. We note further that the charges against the Respondent date back to 1986 through 1990, and the Respondent has apparently committed no subsequent acts of misconduct and has also apparently performed without problems under the probation conditions since June, 1994.

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ORDER

NOW, based upon this Determination, the Review Board issues the following ORDER:

1. The September 30, 1993 Determination by the Hearing Committee on Professional Medical Conduct is modified for the reasons stated in our Determination.

2. The Respondent shall be on probation for a period of five years in addition to the period imposed by the Hearing Committee.

3. The terms of probation are modified as provided in our Determination.

4. The Respondent's license is limited to practice in a facility licensed pursuant to Public Health Law Article 28.

ROBERT M. BRIBER

SUMNER SHAPIRO

EDWARD C. SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

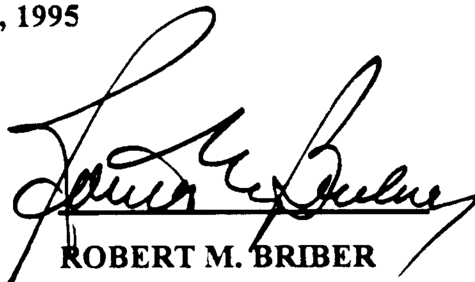
NEW YORK STATE DEPARTMENT OF HEALTH

IN THE MATTER OF ASHOK DHABUWALA, 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. Dhabuwala.

DATED: Albany, New York

Aug 17, 1995



ROBERT M. BRIBER

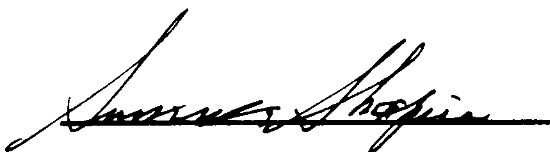
NEW YORK STATE DEPARTMENT OF HEALTH

IN THE MATTER OF ASHOK DHABUWALA, 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. Dhabuwala.

DATED: Delmar, New York

Aug 16, 1995



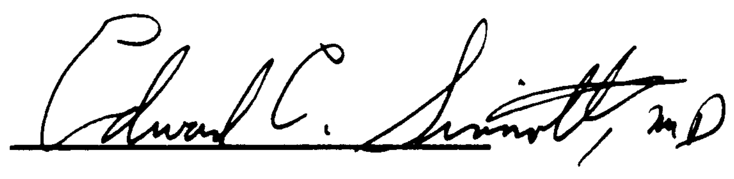
SUMNER SHAPIRO

NEW YORK STATE DEPARTMENT OF HEALTH

IN THE MATTER OF ASHOK DHABUWALA, 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. Dhabuwala.

DATED: Roslyn, New York
August 11, 1995



EDWARD C. SINNOTT, M.D.

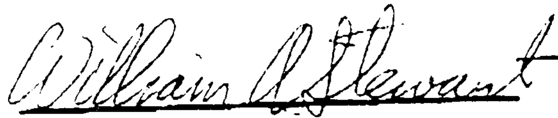
NEW YORK STATE DEPARTMENT OF HEALTH 10

IN THE MATTER OF ASHOK DHABUWALA, 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. Dhabuwala.

DATED: Syracuse, New York

14 Aug 1995, **1995**



WILLIAM A. STEWART, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH

EXHIBIT "F"

Supreme Court - Appellate Division
Third Judicial Department

Decided and Entered: December 26, 1996 75453

In the Matter of ASHOK
DHABUWALA,
Petitioner,
v
STATE BOARD FOR PROFESSIONAL
MEDICAL CONDUCT,
Respondent.

OPINION AND JUDGMENT

Calendar Date: November 12, 1996

Before: Mercure, J.P., White, Yesawich Jr., Peters and Carpinello, JJ.

McAloon & Friedman P.C. (Anthony Z. Scher of Wood & Scher, Scarsdale of counsel), New York City, for petitioner.

Dennis C. Vacco, Attorney-General (Barbara K. Hathaway of counsel), New York City, for respondent.

Peters, J.

Proceeding pursuant to CPLR article 78 (initiated in this court pursuant to Public Health Law § 230-c [5]) to review a determination of the Administrative Review Board for Professional Medical Conduct which, inter alia, permanently limited petitioner's license to practice medicine in New York.

Pursuant to a notice of hearing and statement of charges, petitioner, an obstetrician/gynecologist, was charged by the Bureau of Professional Medical Conduct (hereinafter BPMC) with practicing with gross negligence, negligence on more than one occasion, ordering unwarranted treatment, fraudulent practice and failing to maintain accurate records. The conduct alleged occurred with respect to three patients during the period between 1987 and 1989.

At the conclusion of a hearing held before a Hearing Committee of respondent State Board for Professional Medical Conduct, all charges, other than those alleging gross negligence and that of fraudulent practice, were sustained. However, in the issuance of its order, it was noted that "[a]lthough [petitioner] must bear full responsibility for the serious charges sustained against him, the [Hearing] Committee recognizes that the conduct of others contributed to the inadequate medical care received". Hence, it imposed a two-year suspension of petitioner's license, which was stayed, placed him on probation for two years and required that he submit quarterly reports to the Office of Professional Medical Conduct (hereinafter OPMC) to determine whether his decisions to pursue surgical intervention were appropriate.

BPMC thereafter filed a notice of appeal with the Administrative Review Board for Professional Medical Conduct (hereinafter ARB) to specifically challenge the penalty imposed. The sole request made was for the ARB to "add a requirement that, prior to performing a vaginal or abdominal hysterectomy, [petitioner] be required to obtain a concurring, but independent second opinion from a suitably board certified physician" (emphasis in original). By this simple modification, counsel for BPMC contended that "adequate protection of the public" would be ensured. Counsel for petitioner immediately notified the ARB that based upon their understanding that acceptance of this agreement would circumvent further review, they agreed to the modification.

After setting forth the scope of its permissible review (see, Public Health Law § 230-c), the ARB remanded this matter to the Hearing Committee for more information as to the penalty imposed "or why the Committee feels the penalty is sufficient to protect the public". In so doing, the ARB requested the Hearing Committee to address nine specific questions which included, inter alia, the following:[1]

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[1] The other questions posed by the ARB were as follows:

1. What were the Committee's conclusions regarding the charges of gross negligence and practicing the profession fraudulently?
2. What conduct of others does the Committee feel contributed to the inadequate medical care provided to Patients A, B and C?
3. Why does the Committee limit the review

* * *

> 4. Does the Committee feel that [petitioner']s negligence was the result of poor judgment, poor surgical skills or both?
>
> 5. Is [petitioner] competent to continue practicing surgery?
>
> 6. Does [petitioner] have sufficient knowledge to make the proper judgments in practicing surgery?
>
> * * *
>
> 9. Did the Committee consider sending [petitioner] for an evaluation of his skills as a physician?

The supplemental determination, fully responsive to the questions posed, noted that "[petitioner's] surgical skills were never questioned" and that "[a]ll of [petitioner's] inappropriate treatment was in response to requests or demands from his Supervisory Physician and/or his patients. He used poor judgment in responding to these requests or demands." In response to the particular questions posed, the Hearing Committee advised the ARB that it felt that petitioner's negligence was the result of poor judgment, that he is competent to continue practicing surgery, that he possesses "sufficient knowledge to make the proper judgments in practicing surgery", and that while it considered sending him for an evaluation of his skills, such option was rejected upon its finding that petitioner's negligence was based upon poor judgment "rather than lack of skills".

> of [petitioner's] major operative cases to a two year period?
>
> * * *
>
> 7. Is record review intended as remediation for [petitioner]?
> 8. Is the record review alone enough to correct the deficiencies in [petitioner's] practice?
>
> * * *

Although the ARB sustained the Hearing Committee's determination on the charges, "concerned that [petitioner's] poor judgement may be the result of poor cognitive skills and that * * * [his] negligence and ordering of excessive treatment may indicate a lack of basic knowledge necessary to practice medicine", it modified the penalty by ordering petitioner to undergo an evaluation by the Physician Prescribed Educational Program (hereinafter PPEP).[2] Therein, the ARB detailed that if such evaluation determined that petitioner "possesse[d] the requisite knowledge to safely and effectively practice medicine", the penalty imposed would be probation for a period of two years, with the conditions of probation being those which were originally recommended by the Hearing Committee and then further modified and agreed to by petitioner. If, however, the evaluation determined that petitioner did not possess the requisite knowledge to practice medicine safely and effectively, "then the matter [would] be returned to the [ARB] for a further deliberation on the appropriate penalty".

Petitioner fully participated in the PPEP evaluation. Recognizing that the ARB required PPEP to make only one of those two decisions, the program director concluded that "the findings of the evaluation are not definitive enough to make such a dichotomous decision without bias". The ARB therefore found that because "PPEP * * * was unable to [determine] that * * * [petitioner] could practice medicine safely and effectively", each party was permitted 30 days to provide comments upon the appropriate penalty in this case, based upon the ARB's "findings of misconduct" and upon "the finding from the PPEP Evaluation".

Counsel for BPMC sought revocation of petitioner's license or a suspension with mandatory retraining. Petitioner contended that since the review did not find him unfit to practice medicine, the prior penalty, as modified by agreement, should remain undisturbed. The ARB's final determination and order increased the probationary period to seven years and ordered that petitioner's license be limited to permit him to practice only in a hospital or other facility licensed pursuant to Public Health Law article 28. Petitioner then commenced this proceeding.

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[2] The PPEP program is run under the auspices of the Department of Family Medicine of the State University of New York Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center in Syracuse. It is not a branch of the New York State Department of Health or the State Board for Professional Medical Conduct.

Petitioner contends that the notice requirements of due process preclude an administrative agency from finding a professional guilty of conduct which was not specifically set forth in the statement of charges (see, Matter of Block v Ambach, 73 NY2d 323; Matter of Murray v Murphy, 24 NY2d 150; Matter of Orozco v Sobol, 162 AD2d 834). We agree. The record clearly reflects that the penalty imposed was based upon the uncharged offense of incompetence, a separate act of misconduct under the Education Law (compare, Education Law § 6530 [3], [4], with Education Law § 6530 [5], [6]). OPMC itself specifically distinguishes between negligence and incompetence. In an internal memorandum defining terms relating to professional malpractice, the general counsel to the Department of Health stated that "[n]egligence is applicable to an act or omission of a physician which constitutes a breach of the duty of care [whereas] [i]ncompetence is directed to the lack of the requisite knowledge or skill in the performance of an act". While the ARB's review powers include the authority to increase the severity of a sanction imposed by a Hearing Committee (Matter of Kabnick v Chassin, ___ NY2d ___ [Nov. 14, 1996]), it cannot ground such sanction upon conduct not charged.

The ARB is empowered to review "whether or not the determination and the penalty are consistent with the findings of fact and conclusions of law and whether or not the penalty is appropriate and within the scope of penalties permitted" (Public Health Law § 230-c [4] [b]). Once the Hearing Committee expressly found and concluded, upon reconsideration, that petitioner is competent and possesses the requisite knowledge and skill to practice safely, the ARB's continued challenge to those findings of fact on the issue of petitioner's competence was beyond its authority. Notwithstanding its protestations to the contrary, it is clear from the language employed in its remand to the Hearing Committee, in the supplemental questions posed and in its referral to PPEP that the ARB attempted to undermine the Hearing Committee's findings of fact by conducting additional inquiry into an uncharged offense.

Because "[i]t is axiomatic that due process precludes the deprivation of a person's substantial rights in an administrative proceeding because of uncharged misconduct" (Matter of Block v Ambach, supra, at 332), we annul the determination rendered and remit it to the ARB for further proceedings not inconsistent herewith. In so remitting, we note that once the Hearing Committee issued its supplemental determination and order -- in which it clarified the record below as to its findings and penalty, reiterated that the findings of negligence were based upon poor judgment rather than lack of skills, and concluded that

it had no objection to the stipulated modification of its determination and order with respect to penalty -- the ARB had before it all necessary information upon which to conduct its review.

Mercure, J.P., White, Yesawich Jr. and Carpinello, JJ., concur.

ADJUDGED that the determination is annulled, without costs, and matter remitted to the Administrative Review Board for Professional Medical Conduct for further proceedings not inconsistent with this court's decision.

ENTER:

/s/ Michael J. Novack

Michael J. Novack
Clerk of the Court