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 9, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Marta Sachey, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Nicholas Grasso, Esq.
Grasso, Rodriguez Putorti Grasso and Zyra
751 State Street
Schenectady, New York 12307

Lokendra K. Singh, M.D.
Hutchings Psychiatric Center
620 Madison Street
Syracuse, New York 13210

RE: In the Matter of Lokendra K. Singh, M.D.

Effective Date: 11/16/95

Dear Ms. Sachey, Mr. Grasso and Dr. Singh:

Enclosed please find the Determination and Order (No. 95-266) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

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

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

IN THE MATTER OF LOKENDRA K. SINGH, M.D.	DETERMINATION AND ORDER BPMC-95-266

MICHAEL R. GOLDING, M.D., Chairman, **JOSEPH CHANATRY, M.D.** and **DENISE M. BOLAN, R.P.A.** 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) of the Public Health Law. **MICHAEL P. MCDERMOTT, 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 PROCEEDINGS

Notice of Hearing and Statement of Charges:	January 10, 1995
Pre-Hearing Conference:	February 16, 1995 March 2, 1995
Hearing Dates:	March 2, 1995 April 26, 1995 April 27, 1995 May 23, 1995 July 11, 1995 July 12, 1995 September 7, 1995

Place of Hearing:		Empire State Plaza Albany, New York
Date of Deliberations:		October 2, 1995
Petitioner Appeared By:		Jerome Jasinski, Esq., Acting General Counsel NYS Department of Health
	By:	Marta Sachey, Esq., Associate Counsel
Respondent Appeared By:		Grasso, Rodriguez Putorti Grasso and Zyra 751 State Street Schenectady, New York 12307
	By:	Nicholas Grasso, of Counsel

WITNESSES

For the Petitioner:	1) Patient A 2) Melvin Steinhart, M.D. 3) Sarupinder Singh, D.D.S. 4) John Steminsky 5) Susan Druce 6) Daniel Rowland
For the Respondent:	1) Lokendra K. Singh, M.D., the Respondent 2) Joan Adelson 3) Concetta Van Patten

STATEMENT OF CHARGES

Essentially the Statement of Charges charges the Respondent with conduct evidencing moral unfitness; sexual physical contact in the practice of psychiatry; practicing with gross negligence on a particular occasion; practicing with negligence on more than one occasion; and failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages 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 the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. The Respondent, Lokendra K. Singh, M.D. was authorized to practice medicine in New York State on October 1, 1984 by the issuance of license number 160408 by the State Education Department.

2. The Respondent was duly registered to practice medicine from the date of issuance of his license to the present except for a period of suspension which is reflected in the stipulation in the record (Pet.'s Exs. 1 and 3; Tr. 286).

3. Patient A has filed a lawsuit against the Respondent but the lawsuit has been dormant since August 1992 (Tr. 58-59).

FINDINGS AS TO THE RESPONDENT'S OFFICE BUILDING, OFFICE HOURS AND OTHER TENANTS

4. The Respondent's office building, which he purchased from Dr. Chirpoli in 1987, was located at 1332 Union Street, Schenectady, New York. It is a large old house laid out over

three floors (Resp's. Ex. B; Tr. 312, 313).

5. The first floor consisted of a receptionist area, a waiting area, a kitchen and a small rear room. There were three bathrooms in the building, one on each floor. There were plumbing problems in the building. The third floor bathroom was not usable after the first year and the second floor bathroom was often not in use. There were no problems with the first floor bathroom. The stairs to the third floor were long, narrow and steep (Resp's. Ex. B; Tr. 23-27, 881-882, 885-891, 901, 908, 919, 922).

6. The Respondent's office was on the second floor in the front of the building and he had office hours daily from 5:00 P.M. to 8:00 P.M. or 8:30 P.M. (Resp's. Ex. B; Tr. 303-304).

7. Lois Litgow was the Respondent's secretary and office manager. She was scheduled to be on duty from 4:00 P.M. until the conclusion of office hours, but there is insufficient evidence to determine at what time she actually left the premises (Tr. 448).

8. Dr. Park rented office space in the rear of the second floor until 1989. He and his staff were on the premises on a full time basis (Tr. 307, 310, 314, 587-588).

9. The third floor of the building was essentially an attic. Susan Druce, a certified social worker, rented a small office in the rear of the third floor in approximately 1987-88. In 1990 she moved to the second floor offices originally occupied by Dr. Park.
Mrs. Druce's office hours were from 8:00 A.M. to 3:00 P.M. daily. She also had evening office hours, always on a Wednesday evening, but sometimes also on Monday and/or Thursday evening. She saw approximately 30-40 patients per week
(Resp's. Ex. B; Tr. 881-883)

10. Joan Adelson, a certified social worker, rented office space from the Respondent commencing in 1988. Her office hours were 7:00 P.M. to 9:00 P.M. on Tuesday, Wednesday and Thursday. Her case load varied from 5 to 7 patients (Tr. 726, 728, 735).

11. Concetta Van Patten, a certified social worker, rented office space commencing in March, 1988. Her office hours were 5:15 P.M. to 7:00 P.M., Tuesday, Wednesday and Thursday. Her case load was 10 patients (Tr. 764-766).

12. All of the tenants had open, unrestricted, unlimited and independent access to the building (Tr. 400-401, 904-905).

CONCLUSIONS

The Respondent's office building was essentially an old house. There were five tenants, two psychiatrists, including the Respondent, and three certified social workers. Each tenant had his/her own offices and they were all engaged in the mental health profession. Despite the numbers of tenants and patients, there was a significant degree of confidentiality and privacy given the nature of the profession and the layout of the building.

FINDINGS AS TO PATIENT A

13. Patient A is a woman in her forties, living with her husband of her third marriage. She is a high school graduate and has worked as a secretary at General Electric for the last 131/2 years. She also worked part-time for four years at a nursing home as a "recreation person" (Tr. 13-14, 16, 95, 578-579).

14. The Respondent provided medical care in the form of psychiatric treatment to Patient A from February 5, 1987 to February 10, 1987 at Ellis Hospital, Schenectady, New York and at his offices at 1332 Union Street, Schenectady, New York from February 12, 1987 to April 29, 1987 and from December 10, 1987 to September 15, 1988 (Pet's. Exs. 4 and 6).

15. Patient A was admitted to Ellis Hospital on February 5, 1987 because she had attempted suicide. Her second husband was cheating on her, they were separated, and she "just fell apart." The Respondent was assigned to her case; They had never met before. Her hospital stay was for five days (Pet's. Ex. 6; Tr. 14-17, 78-82, 324, 326, 331).

16. The Respondent saw Patient A at his office for follow-up psychiatric care after she was discharged from the hospital (Pet's. Ex. 6 p. 5; Tr. 335-336).

17. Patient A's office appointments with the Respondent were as follows:

February 2, 1987-Thursday
February 18, 1987-Wednesday
February 25, 1987-Wednesday
March 4, 1987-Wednesday
April 1, 1987-Wednesday
April 29, 1987-Wednesday
December 10, 1987-Thursday
January 28, 1988-Thursday
February 25, 1988-Thursday
March 30, 1988-Wednesday
June 16, 1988-Thursday
September 15, 1988-Thursday
(Pet's. Ex. 4; Resp's. Ex. E).

18. Patient A also saw the Respondent at his offices on May 15, 1989 to ask him to get her medical records from Oswego. No treatment was rendered at that time (Tr. 108-109, 564, 567, 580-581).

19. Patient A's appointments with the Respondent were always in the evening, anywhere between 6:30 and 8:30 p.m. She worked until 5:00 p.m., necessitating evening office visits (Tr. 18-19).

CONFLICTING TESTIMONY

PATIENT A'S TESTIMONY

Patient A testified that the Respondent had discussed matters relating to his personal circumstances during his treatment sessions with her. She said that she had asked him if he was married and that he told her that he was, but that the marriage had been arranged. He told her that he was going to leave his wife after his children got out of high school. He also mentioned that his wife worked at a school (T. 21-22)

In fact, the Respondent's marriage was an arranged one and he did have long standing marital problems, which continued during the time he was treating Patient A. His children were in high school and he was in fact separated from his wife at the time. Also, the Respondent's wife, did work at a school (Tr. 507-508, 596).

Patient A testified that the Respondent kissed her on the lips at the end of her appointments on approximately three or four different occasions. She was indefinite about the dates but approximated the time as near the beginning of the middle of her treatment course with the Respondent. She claims that the Respondent's office door would be slightly ajar as they were about to exit the office and that he would place his left hand on her shoulder, and sometimes towards her back, and kiss her on the lips. The kisses were short, lasting only about four seconds. The Respondent said nothing when he kissed her and afterwards he escorted her to the first floor and the

next appointment was scheduled (Tr. 27-31, 143-145, 251-253).

Patient A testified that she reacted to the Respondent's kissing her with confusion and also with some pleasure: "I wasn't sure what was going on because he never said anything...but I think I enjoyed them." She said that the Respondent's contact made her feel "special, wanted, needed." Her self-esteem at the time was low and she viewed herself as fat and ugly. She did not know why the Respondent picked her when she felt that he could get anybody he wanted (T. 29-33). Gaining weight was an issue which she had discussed with the Respondent (Pet's. Ex. 4; Tr. 240-242).

Patient A testified that the Respondent's physical contacts escalated. Again she was indefinite about dates, but claims that this occurred toward the middle of her treatment course. She said that at the end of a treatment session the Respondent kissed her as they were exiting his office, as he had done previously. However, on this occasion the Respondent kissed her for a longer period of time and the kiss was more of a passionate kiss than the previous ones (Tr. 33). After the Respondent kissed her he asked her if she wanted to go upstairs. Patient A claims that she had never been on the third floor of the Respondent's office building prior to this time. However, she assumed there was a bedroom on that floor because the Respondent had told her he had lived there when they had discussed his marriage. She agreed to go upstairs with the Respondent (Tr. 33-34, 134, 179-180, 227).

Patient A described the contents of the third floor room. She said that it contained a bed, dresser and a chair. She also observed that the room was in the front of the building (Tr. 23-27). She sat on the bed and began to get undressed. She remembered that she was wearing a pair of light blue corduroy pants. The Respondent removed his clothes and "put them neatly on the chair." He was naked. He came over to her to help her finish undressing. She put his penis in her mouth. The Respondent went to the bottom drawer of the dresser to get a condom. She told him that a condom was not needed because her tubes were tied. They laid on the bed, he fondled her breasts and vagina and then they had sexual intercourse. The act of sexual intercourse did not last long (Tr. 34-37, 136-137, 148).

Patient A observed that Respondent was not circumcised. She had not previously been with a man who was not circumcised (Tr. 36). The Respondent, in fact, is not circumcised (Stipulation, Tr. 8). Patient A also observed that the Respondent's penis was big, that his skin was soft and that he smelled very good (Tr. 36). After the sexual intercourse, the Respondent got up and got washed and dressed. Patient A did not know where he went to wash. She got dressed and they went to the downstairs kitchen and kissed "a little bit." Then the Respondent walked her to the front door and told her that he felt "all tingly inside." (Tr. 37, 139).

Patient A also testified that on two subsequent occasions, when she was the Respondent's last scheduled appointment, they had sexual intercourse on the floor of his office. On those occasions there was no oral sex. On one of those occasions the Respondent had suggested that she come to his office at 10:00 P.M. after his other patients were gone (Tr. 39, 148, 224).

Patient A testified that her reactions to these sexual encounters were complex in that she felt guilty and confused, but at the same time she felt good because they made her feel special (Tr. 37-40, 228, 277).

Patient A stopped going to the Respondent sometime in late 1988 or 1989 because she felt she could no longer see him. She and the Respondent never discussed termination of therapy or the needs she might have for further therapy or whether she should be under the care of another psychiatrist (Tr. 40-41, 53-54).

RESPONDENT'S TESTIMONY

The Respondent contends that his disclosure of some aspects of his personal life to Patient A were occasioned by her asking some questions about a photograph on his desk, and amounted to no more than off-handed casual remarks.

He maintains that Lois Litgow, his secretary and office manager, reported for work at 4:00 P.M. and remained until all patients were seen and left the building, and that he was never in the building alone without Lois Litgow being present (Lois Litgow did not testify).

The Respondent contends that Patient A's allegations of physical contact, kissing and sexual intercourse are not true.

HEARING COMMITTEE DISCUSSION REGARDING THE CREDIBILITY OF PATIENT "A" AND THE RESPONDENT

PATIENT A

The Hearing Committee concludes that Patient A testified candidly and directly. Her testimony was substantially consistent during direct examination, rigorous cross-examination and the Hearing Committee's questioning.

She shared with the Committee the most intimate details of her life and feelings. She spoke openly of her personal and family background (Tr. 62-68). She was candid about her prior psychiatric problems and suicide attempts (Tr. 68-69, 78) She shared the details of her marriages (Tr. 70-74). She was also open about her sense of guilt regarding her involvement with the Respondent, a married man. Her answers on cross-examination regarding the very specific and numerous details of what transpired when Respondent had sexual intercourse with her the first time were consistent with her direct testimony account of that event (Tr. 126-139). She did not embellish or exaggerate the particulars of the Respondent's conduct.

Facts incidental to Respondent's sexual contact with the patient, denied by the Respondent at the hearing, were confirmed by disinterested witnesses. The fact that there was a bedroom on the third floor was confirmed by the Respondent himself to an OPMC investigator in a 1992 interview (Tr. 969). Ms. Duce, whose office was across from the bedroom until approximately 1990, also testified that she had observed the bed and dresser in the room (Tr. 887-889).

Patient A told her subsequent treating health professionals of the Respondent's sexual relationship with her (Panel Ex. 1; p. 45 Pet's. Ex. 12, p.2; Tr. 57-58).

Patient A's reactions and motivations regarding the Respondent's conduct, were those that would be expected from any patient in similar circumstances (Tr. 644-645). The life situation

which prompted Patient A to see the Respondent, as evident in the Respondent's own records, made her especially vulnerable to the Respondent's conduct (Pet's. Ex. 4, p.10 (4/1/87 Entry)

Patient A was not delusional (Tr. 607). There is nothing in the Respondent's records or other medical records that evidenced by history or status that Patient A was delusional, hallucinatory or a fabricator (Tr. 646). There is no evidence in the Respondent's records that the Patient acted inappropriately, had sexual fantasies about the Respondent or was sexually provocative (Tr. 694-695).

THE RESPONDENT

The Respondent's testimony was inconsistent with material prior statements. On direct examination he told the Committee that he knew the requirements for admission to the Riveredge Hospital (Tr. 456-457). In fact, he did not know those requirements (Tr. 506-507).

The Respondent told the Committee that the third floor room contained a broken cot which was left behind by the previous owner (Tr. 475-776). However, in 1992, he told an OPMC investigator that the third floor had a bedroom which contained a single bed (Tr. 969). At the time of the 1992 interview, the Respondent was aware of the importance of the third floor room and Patient A's knowledge of its layout and contents (Tr. 546, 547, 549). At the hearing he told this Committee that Patient A would have known about the third floor because he specifically remembered that he directed her to use the third floor bathroom at the beginning or end of a treatment session (Tr. 441-442, 544-546). However, he never mentioned this to the OPMC investigator in 1992. Rather, he told the investigator that the patient somehow must have wandered up to the third floor (Tr. 965).

The Respondent was not a credible witness in significant areas of his testimony.

FINDINGS AS TO THE RESPONDENT'S TELLING PATIENT A SOME ASPECTS OF HIS PERSONAL CIRCUMSTANCES

20. The Respondent told Patient A that his marriage had been arranged; that he was having problems with the marriage and that he was going to leave his wife after his children got out of high school (Tr. 21-22).

FINDINGS AS TO SEXUAL MISCONDUCT

21. On numerous occasions, at the end of Patient A's appointments at his office, the Respondent placed his hand on Patient A's lower back and kissed her on the lips (Tr. 27-31, 143-145, 251-253).

22. At the end of one of Patient A's appointments at his office, the Respondent kissed Patient A on the lips for a longer time than he had done on prior occasions. He took Patient A to the third floor bedroom in his office building and engaged in sexual intercourse with her (Tr. 23-27, 33-37, 136-137, 148, 179-180).

23. On two subsequent occasions, at the end of Patient A's appointments at his office, the Respondent engaged in sexual intercourse with Patient A on the floor of his office (Tr. 39, 148, 224).

FINDINGS AS TO LITHIUM PRESCRIPTIONS

24. The Respondent prescribed lithium over the telephone for Patient A after the last office visit of May 18, 1989. He did so on October 4, 1989 five months after the Patient's last office

visit. He also called in a Lithium prescription for Patient A on October 10, 1991 (Pet's. Ex. 4, p. 14; Ex. 5; Ex. 9; Tr. 42-55, 120, 130-131, 189-192, 810, 832-834, 836, 839, 843, 858-859, 865, 869-870, 878).

25. The Respondent did not arrange for monitoring Patient A's Lithium level despite calling in the prescription (Pet's. Ex. 4, p. 14; Tr. 47, 520-521).

26. There is no evidence in the Respondent's records that Patient A sought drugs for abuse. The pharmacy printout of the patient's medications was not indicative of a patient abusing drugs (Tr. 645-646, 696-697).

FINDINGS AS TO RESPONDENT'S MEDICAL RECORDS FOR PATIENT A

27. The Respondent's medical records for Patient A did not report treatment goals and interim status examinations. There are no treatment plans and basically nothing in the records indicate where the treatment was going (Pet's. Ex. 4).

28. On December 10, 1987, the Respondent saw Patient A for the first time since April 29, 1987. The records for December 10, 1987 visit were sparse and totally inadequate given the fact that the Respondent had not seen the Patient for approximately eight months. The Respondent noted that the Patient was stabilized on Lithium, however, there is not notation regarding the Patient's history of the use of this drug (Pet's. Ex. 4, pp. 9-10).

29. On January 28, 1988, the Respondent prescribed Lithium for Patient A. A February 1, 1988 Lithium blood level was 0.2 , lower than the therapeutic range. The Respondent was aware of this test result before he saw the Patient again on February 25, 1988, yet he did not record whether the Patient was taking Lithium regularly or whether he arranged for further Lithium

level testing (Pet's. Ex. 4; Tr. 540, 637-639).

30. The Respondent phoned in several prescriptions for Patient A to the pharmacy, but he made no record of these patient contacts other than a notation on the medication sheet (Pet's. Ex. 4, p. 14).

31. The Respondent's records for Patient A were inadequate for a subsequent treating psychiatrist to provide the Patient a continuum of care if the Respondent were unable to care for her (Pet's. Ex. 4; Tr. 637-639).

VOTE OF THE HEARING COMMITTEE

FIRST SPECIFICATION: Conduct Evidencing Moral Unfitness:

SUSTAINED As to the charges specified in paragraphs A, A(2), A(3)(i), A(3)(ii) and A(4) of the Statement of Charges.

SECOND SPECIFICATION: Sexual Physical Contact in the Practice of Psychiatry:

SUSTAINED As to the charges specified in paragraphs A(2), A(3)(i), A(3)(ii) and A(4) of the Statement of Charges.

THIRD AND FOURTH SPECIFICATIONS: Practicing With Gross Negligence on a Particular Occasion:

SUSTAINED As to the charges specified in paragraphs A, A(2), A(3)(i), A(3)(ii), A(4) and A(5) of the Statement of Charges.

FIFTH SPECIFICATION: Practicing With Negligence on More Than one Occasion:

SUSTAINED As to the charges specified in paragraphs A(1)(i), A(1)(ii), A(1)(iii) A(1)(iv), A(2), A(3)(i), A(3)(ii), A(4) and A(5) of the Statement of Charges.

SIXTH SPECIFICATION: Failing To Maintain a record Which Accurately Reflects the Evaluation and Treatment of the Patient:

SUSTAINED As to the charges specified in paragraphs A(6) of the Statement of Charges.

HEARING COMMITTEE DETERMINATIONS

The Respondent's actions in having sexual relations with his patient is a gross violation of professional ethics and evidences a moral unfitness to practice medicine.

The Hearing Committee determines unanimously (3-0) that the Respondent's license to practice medicine in the State of New York should be **REVOKED.**

At a pre-hearing conference in this matter, held on February 16, 1995, the Administrative Officer ruled that Petitioner's Exhibit 7, New York State Board for Professional Medical Conduct ORDER 92-28, should be marked "For Identification", and that it would be revealed to the Hearing Committee only if the charges in this instant matter were sustained, at which time the Hearing Committee could take ORDER 92-28 into consideration in determining penalty.

ORDER 92-28 was revealed to the Hearing Committee after the Committee voted to sustain the instant charges against the Respondent, and after the determination by the Committee that the Respondent's license to practice medicine should be revoked. ORDER 92-28 just confirms the Hearing Committee's Determination that the Respondent is morally unfit to practice medicine.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

2. The Hearing Committee further **ORDERS** that should the Respondent apply for the reinstatement of his license in the future, his application must be accompanied by a complete psychiatric evaluation by a psychiatrist who is familiar with the Respondent's history of sexual misconduct and who is approved by the Office of Professional Medical Conduct.

3. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York
31 OCT **1995**

MICHAEL R. GOLDING, M.D., Chairman

JOSEPH CHANATRY, M.D.
DENISE M. BOLAN, R.P.A.

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	NOTICE
OF	:	OF
LOKENDRA K. SINGH, M.D.	:	HEARING

TO: Lokendra K. Singh, M.D.
Hutchings Psychiatric Center
620 Madison Street
Syracuse, New York 13210

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 Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 2nd day of March, 1995, at 10:00 a.m. in the forenoon of that day at the Empire State Plaza, New York State Cultural Education Building, Conference Room B, Concourse Level, Albany, New York 12230 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 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 Section 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, Section 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 Section 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 THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
January 10, 1995

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

E. Marta Sachey
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
LOKENDRA K. SINGH, M.D.	:	CHARGES

----------X

LOKENDRA K. SINGH, M.D., the Respondent, was authorized to practice medicine in New York State on October 1, 1984 by the issuance of license number 160408 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 June 30, 1997 at Hutchings Psychiatric Center, 620 Madison Street, Syracuse, New York 13210.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A (identified in the Appendix) from approximately February 5, 1987 through February 10, 1987 at Ellis Hospital, 1101 Nott Street, Schenectady, New York 12308 and from approximately February 12, 1987 through October 10, 1991 at his office at 1332 Union Street, Schenectady, New York 12308 [hereafter "office"] and/or by telephone.

1. Respondent, during Patient A's appointments at his office, told Patient A the following regarding his personal circumstances:

(i) Respondent told Patient A that he was having problems with his marriage or words to such effect.

(ii) Respondent told Patient A that he had been living on the third floor of the building in which his office was located for a period of time or words to such effect.

(iii) Respondent told Patient A that his marriage was one that had been arranged or words to that effect.

(iv) Respondent told Patient A that he was going to leave his wife after his children were through with high school or words to such effect.

2. Respondent, on numerous occasions at the end of Patient A's appointments at his office, placed his hand on Patient A's lower back and kissed Patient A on the lips.

3. Respondent, at the end of one of Patient A's appointments at his office, engaged in the following contact with Patient A:

(i) Respondent kissed Patient A on the lips for a longer time than he had done on prior occasions.

(ii) Respondent took Patient A to the third floor of the building in which his office was located and engaged in sexual intercourse with Patient A.

4. Respondent, on two other occasions, at the end of Patient A's appointments at his office, engaged in sexual intercourse with Patient A in his office.

5. Respondent, on several occasions, including approximately October 4, 1989 and/or October 10, 1991, called in and/or issued lithium prescriptions for Patient A without having seen and examined Patient A within an appropriate period of time and/or without having arranged for monitoring Patient A's lithium level.

6. Respondent failed to maintain adequate records for Patient A.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1994) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

1. The facts in Paragraphs A and A.2, A and A.3(i), A and A.3(ii) and/or A and A.4.

SECOND SPECIFICATION

SEXUAL PHYSICAL CONTACT IN THE PRACTICE OF PSYCHIATRY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(44) (McKinney Supp. 1994) by reason of his, in the practice of psychiatry, engaging in physical contact of a sexual notice with a patient, in that Petitioner charges:

2. The facts in Paragraphs A and A.2, A and A.3 (i), A and A.3(ii) and/or A and A.4.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE ON
A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1994) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

3. The facts in Paragraphs A and A.2, A and A.3(i) A and A.3(ii) and/or A and A.4.

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

FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON
MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) (McKinney Supp. 1994) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two of more of the following:

5. The facts in Paragraphs A and A.1(i), A and A.1(ii), A and A.1(iii), A and A.1(iv), A and A.2, A and A.3(i), A and A.3(ii), A and A.4, and A and A.5.

SIXTH SPECIFICATION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1994) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and

treatment of the patient, in that Petitioner charges:

6. The facts in Paragraph A and A.6.

DATED: Jan. 10, 1995
Albany, New York

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