STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

June 24, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin P. Donovan, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

T. Lawrence Tabak, Esq.
Tabak & Stimpl
190 EAB Plaza
East Tower – 15th Floor
Uniondale, New York 11556-0190

Pankaj T. Desai, M.D.
114 Danberry Circle
New Hartford, New York 13413

RE: In the Matter of Pankaj T. Desai, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-162) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

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

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

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

Sincerely,

James F. Horan/cah

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

PANKAJ T. DESAI, M.D.

DETERMINATION

AND

ORDER

BPMC # 03-162

A Commissioner's Order, Notice of Hearing and Statement of Charges, each dated October 9, 2002, was served by First Class mail and Federal Express upon the Respondent, **PANKAJ T. DESAI, M.D.** **WILLIAM K. MAJOR, JR., M.D.**, Chairperson (replacing **JOEL H. PAULL, D.D.S., M.D., J.D.**), **WALTER T. GILSDORF, M.D.**, and **MS. DEANNA KRUSENSTJERNA**, 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 (12) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Law Judge for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF PROCEEDINGS

Substituted mail service of Commissioner's Order, Notice of Hearing and Statement of Charges:	October 15, 2002
Pre-Hearing Conferences:	October 18, 29, 2002
Hearing Dates:	October 18; November 4, 14, 18, 19; December 2, 3, 11, 12, 17, 30, 2002; January 17; February 6, 7, 2003
Commissioner's Interim Order:	January 9, 2003
Department of Health appeared by:	**DONALD P. BERENS, JR., ESQ.**, General Counsel, New York State Department of Health, 2509 Corning Tower, Empire State Plaza, Albany, New York 12237-0032 BY: **KEVIN P. DONOVAN, ESQ.**

Respondent appeared by:	Tabak & Stimpfl East Tower, 15th Floor Uniondale, New York 11556-0190 BY: **T. LAWRENCE TABAK, ESQ.**
Witnesses for Department of Health:	Patient B Patient G Patient E Patient D Patient C Patient I Patient F Patient H Nurse M Darlene V. Dunn Philip C. Bonanno, M.D.
Witnesses for Respondent:	Susan Morton-Brin, R.N. Kalpana Desai, M.D. Paula Moynahan, M.D. Margaret Kowalski, M.D. Pankaj T. Desai, M.D. (Respondent)
Receipt of Submissions (Close of Record):	March 7, 2003
Deliberations held:	March 13, 14, 31, 2003

LEGAL ISSUES

- The Department made a series of unsuccessful attempts to personally serve Respondent at his home and two medical offices. Arrangements were then made to personally serve Respondent at his then-attorney's offices on October 12, 2002. Respondent did not appear for that appointment and thereafter replaced his attorney with another. He was present at that attorney's offices on or about October 15, 2002; however, Department's counsel was informed that Respondent would not be made available to receive service. Subsequently, the Department sent copies of the Commissioner's Order, Notice of Hearing and Statement of Charges to Respondent by First Class mail and Federal Express. At the initial prehearing conference on October 18, 2002, the ALJ ruled that Respondent's actions demonstrated an intent to avoid personal service, that the Department had exercised due diligence in attempting to personally serve Respondent pursuant to the requirements of Public Health Law Section 230.10(d) and that therefore service had been properly completed.

- The original Chairperson, Dr. Paull, disclosed a possible conflict-of-interest in that he had previously been contacted to offer an opinion of Respondent's care and treatment of a patient (one not associated with this proceeding) in an earlier civil action brought against Respondent. He indicated no recollection of any opinion he may have rendered and stated he believed he could objectively judge the allegations brought against Respondent in this case. Respondent made a motion for Dr. Paull's recusal which the Department initially opposed and which was denied by the Administrative Law Judge. Subsequently, counsel for the Department notified the Administrative Law Judge *ex parte* of a change of position to that of joining Respondent's motion for recusal. As there was no longer opposition to the motion, the ALJ then granted it prior to advising Respondent's counsel of such decision. The circumstances of arriving at that decision were set forth on the record at the next day of hearing. Following two days of hearing, Dr. Paull was replaced as Chairperson by Dr. Major, who affirmed that he had read the transcript of the two days at which he had not been present.

- Respondent indicated a refusal to waive the provision found in Section 230.12 which requires that a hearing on the issue of imminent danger be completed within ninety days of service of the summary suspension order. The same statute further provides that when both parties have completed their cases with respect to the question of imminent danger, the Committee shall promptly make a recommendation as to whether the summary order should remain in effect, be modified or be vacated. Although the Committee met for eleven days of hearing during the ninety day period, it became apparent by December 30, 2002 that Respondent would not complete his case on the issue within the prescribed period. The ALJ instructed the Committee that the two mandates of Section 230.12 were inconsistent and therefore he had the discretion, based on the particular circumstances of the instant case, to decide when the Committee should make the imminent danger determination.

Respondent completed five days of testimony on December 30, 2003 during which he addressed all issues related to his treatment and care of eleven patients. The ALJ determined that the Committee had sufficient evidence to make a reasoned determination before the expiration of the Commissioner's Order as to whether Respondent's practice of medicine would constitute an imminent danger to the public. Following oral argument by both parties on that subject, the Committee made a finding that Respondent, in fact, did present an imminent danger to the health of the people of New York state and

recommended that the Commissioner's Summary Suspension Order remain in effect pending final resolution of this matter. An Interim Order by the Commissioner, adapting such recommendation, was signed on January 9, 2003.

- The Committee holds the opinion that the fact that this was a summary suspension proceeding necessitated the exercise of appropriate prosecutorial discretion in drafting the Statement of Charges and in determining which Allegations to actively pursue during the course of the proceeding. Certain charges, particularly those after Paragraph O, were viewed as both cumulative and repetitive in nature, and served to unreasonably extend the period deemed necessary to make a determination and to draft this report. The Committee was able to clearly determine the nature of Respondent's medical practice and his personal character in reviewing the care and treatment rendered to the dozen patients involved in this matter.

- Factual Allegation E and E. 5. of the Statement of Charges (Ex. 1) was amended to read May 8, 1998 and Factual Alegation H.2. was amended to read September 15, 2000. The Department withdrew Factual Allegations L.1., L.2., L.5. and N. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for certain types of professional misconduct.

The following definitions were relied upon by the Hearing Committee during its deliberations:

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

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

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

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

Fraudulent practice of medicine is the intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining 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.

Conclusions of law were made pursuant to the Findings of Fact listed below. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T. = Transcript

GENERAL FINDING OF FACT

1. The Respondent was authorized to practice medicine in New York State on May 15, 1987 by the issuance of license number 170132 by the New York State Education Department. (Ex. 2)

FINDINGS RELATED TO PATIENT A

2. Patient A, a 5 year old male, was brought to the emergency department of St. Luke's Hospital on July 24, 1998 after his leg had been lacerated when it had gone through a window. (Ex. 4, p. 4)

3. The Emergency Department physician noted the patient as having deep complex lacerations in the back of his right leg and as being able to move the right leg well. Respondent reviewed this note and discussed the case with the Emergency Department physician and the patient's mother. (Ex. 4, p.4; T. 1019)

4. There are two aspects of performing a physical examination of a patient before the surgery, vascular and neural. Pre-operatively, Respondent reported lateral and medial plantar nerve distribution sensation, which is a partial evaluation of the peroneal nerve. There was no examination of motor function, tested by dorsiflexion of the foot. There was no documentation in the record that the child did not cooperate with the physical examination. (Ex. 3-4; T. 756-7)

5. Respondent's plan to treat Patient A's injury was to close the laceration. A local anesthetic was utilized during the Emergency Room procedure. (Ex. 4, p.9)

6. Two concerns for repair of an injury such as this are vascular and neural. A proper neural examination would have demonstrated a nerve injury that would have required repair. During his exploration, Respondent never identified or assessed the peroneal nerve. (T. 766-768, 788)

7. Patient A was seen in Respondent's office for follow up on July 30, 1998. An adequate assessment of the wound required the removal of the bandage and splint, at which time nerve function could have been tested. There was no indication in the medical record that the bandage and splint were removed. (Ex. 3, p.10; T. 2354-5)

8. The patient's mother informed Respondent at a follow up visit on August 3, 1998 that the patient could not spread his toes and had decreased sensation in his foot. Respondent then referred Patient A to a pediatric orthopedist. (Ex. 3, p.10)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT A

The Committee **SUSTAINED** Factual Allegations A.2., A.5., A.6. and A.8. All other Factual Allegations related to Patient A were **NOT SUSTAINED**.

The Committee concluded that the four sustained Allegations constituted the practice of medicine with negligence and with incompetence on more than one occasion, but did not rise to the level of gross negligence or gross incompetence.

The Committee believed that the appropriate standard of care for treating Patient A required Respondent to identify and assess the condition of the peroneal nerve for the purpose of satisfying himself as to its integrity. There was no evidence that the child was in such distress so as to make it impossible to conduct such an evaluation of the nerve. Respondent was expected to have known that a proper exploration of the wound would have included such an identification and assessment.

The post-operative office visit of July 30, 1998 was so poorly documented that it could not be determined what actions, if any, Respondent undertook to evaluate Patient A's progress. At a minimum, removal of the bandage and splint that were in place was required; there was no evidence that Respondent did so.

The Committee concluded that the pre-operative history Respondent received from the Emergency Department physician and patient's mother, in addition to the note written by the physician, was adequate under the circumstances. The Committee did not sustain A.3., A.4. and A.7. based on reasoning that the actions taken by Respondent, *having missed the nerve injury*, were appropriate. As stated above, Respondent should have observed such injury when exploring the wound. The misdiagnosis also led to the failure to refer the patient to a specialist at the first follow-up visit on July 30,1998. The complaint of complications at the August 3, 1998 office visit justified the referral to a pediatric orthopedist, which was adequately documented in the record.

FINDINGS RELATED TO PATIENT B

9. Patient B, a 35 year old female, went to Respondent's office on May 12, 1993 for an examination of an indentation in her right buttock area. Although he looked at the indentation on her right side, Respondent recorded a note which indicated that the depression was in her left buttock region. (Ex. 6 at 111, T. 38, 810).

10. Respondent performed a biopsy on the patient's right buttock on May 19, 1993. In his operative note Respondent reported that the patient had a depression in her left buttock region. (Ex. 6, p.104, T. 41-2)

11. The biopsied specimen was sent to a local laboratory for analysis. In a letter to the Mayo Clinic dated May 26, 1993 in which a consulting opinion was requested, the local pathologist offered the opinion that he favored a diagnosis of a well differentiated lipoma-like sarcoma. (Ex. 8)

12. The consulting opinion offered by a pathologist at the Mayo Clinic, dated May 28, 1993, was that the specimen represented a lipoma with fibrosis and atrophic features. This opinion was adapted by the local pathologist in a report dated June 8, 1993. (Ex. 6, pp. 99, 103)

13. Respondent recorded a note dated May 26, 1993 in which he indicated that the results of the pathology report were revealed to Patient B and that a wide excision of the tumor was recommended as a course of treatment. He also advised the patient that there was a 90% chance of a recurrence of the lesion in the future. (Ex. 6, p. 102; T. 44)

14. A lipoma is a benign neoplasm, whereas a liposarcoma is a malignant lesion. (T. 813)

15. Respondent performed a wide excision of the lesion on June 2, 1993. His operative report indicated both the pre- and postoperative diagnosis as "possible malignant lesion, liposarcoma of the right gluteal region". Respondent had not received the final written pathology report from the May 19, 1993 biopsy when he recorded such diagnoses. (Ex. 6, pp. 95-6, 99-103)

16. Respondent failed to inform Patient B that the final pathology report indicated a diagnosis of a benign lesion. Respondent caused her to believe that the wide excision procedure had removed malignant tissue. Patient B had many subsequent visits as recommended by Respondent to follow up for cancer. (Ex. 6, pp. 94-97; T. 49, 52)

17. Respondent recorded a note dated September 11, 1996 in which he addressed the patient's desire for laser resurfacing of the face. A medical history was obtained and documented and the risks of the procedure were discussed. He performed the laser resurfacing surgery on September 25, 1996. The patient signed a consent for such surgery on that day and acknowledged she was made aware of the potential risks involved. (Ex. 6, pp. 56-8, 65)

18. The results of Patient B's laser resurfacing were unsatisfactory in that she incurred either a herpetic or bacterial infection or epidermolysis secondary to the laser going too deeply into the epidermis. (T. 835)

19. A Licensed Practical Nurse employed by Respondent calibrated the laser equipment in Respondent's medical office prior to the laser resurfacing procedure performed on Patient B. Subsequent to that procedure, Respondent's office manager contacted a representative of the company that provided the equipment. He indicated that Respondent was supposed to contact him by telephone for assistance in calibrating the laser prior to its use. (T. 722-3)

20. Respondent received a letter from the American Society of Plastic and Reconstructive Surgeons dated March 4, 1996 which informed him that he had not satisfied the Society's requirements for Active Membership and that his name was therefore removed from the list of

Candidates for Membership. He used a letterhead with the symbol and name of the American Society of Plastic and Reconstructive Surgeons on his operative report dated September 25, 1996 for Patient B's laser resurfacing procedure. (Ex. 6, p. 56, Ex. 52, p. 80)

21. Respondent's record does not accurately state complaints and condition of the patient post-operatively in that he wrote in several notes that the patient was healing well from the facial resurfacing surgery, when she was actually in great discomfort and not satisfied with her recovery. (Ex. 6, pp. 53-5; T. 67-70)

22. Respondent's record stated that he obtained a culture from the patient at a October 7, 1996 office visit. There was no culture report in the chart and no documentation that Respondent appropriately followed-up on indications of an infection. (Ex. 6, p.55)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT B

The Committee **SUSTAINED** Factual Allegations B.1., B.4. (by majority vote), B.5., B.6., B.7., and B.9.through, and including, B.13. All other Factual Allegations related to Patient B were **NOT SUSTAINED**. (Allegation B.3. was not sustained by majority vote.)

B.1.- It was obvious that Respondent's medical record was inconsistent as to the location of Patient B's lesion. The Committee considered the errors to constitute the negligent practice of medicine.

B.2.- The status of the biopsied specimen had not been definitively determined when Respondent wrote the May 26, 1993 note and recommended a wide excision. The Committee assumed Respondent had spoken with the local pathologist about his preliminary impressions. In the request to the Mayo clinic for a consult, the pathologist wrote that he favored a well differentiated lipoma-like liposarcoma. The Committee reasoned that Respondent's note was accurate when written and that he believed that the specimen was malignant. The Factual Allegation was not sustained.

B.3.- The recommendation for a wide excision was considered to be indicated based on the clinical characteristics and preliminary opinion from the pathologist. The Committee member voting in the minority believed that Respondent should have waited for a final pathology report before making his recommendation.

B.4.- Respondent did not have a final, definitive diagnosis on June 2, 1993 when he described the operative procedure as having performed a "wide excision of the malignant lesion". The majority felt that this was evidence of practicing with negligence and incompetence, but believed that this was not the fraudulent practice of medicine as there was no intent to mislead. The Committee member voting in the minority considered Respondent's operative report to be consistent with his preoperative diagnoses and, even if ultimately not accurate, that Respondent believed at that time that the lesion was malignant.

B.5., B.6. and B.7.- There was no documented evidence that Respondent ever informed Patient B that the final pathology report indicated that the lesion was a lipoma with fibrosis and atrophic features; *i.e.*, not malignant. The Committee considered the final report, based on the Mayo Clinic consult, to be clear and unequivocal. The Committee further considered that Patient B credibly testified that Respondent caused her to believe that a malignancy had been removed by the wide excision and that continued follow-up was necessary. The Committee determined that the failure to clarify the diagnosis and his encouragement of unnecessary follow-up visits were egregious errors that were of the level of the practice of the profession with gross negligence and gross incompetence. Specifications of practicing the profession fraudulently and with conduct evidencing moral unfitness were also sustained based on Respondent's intentional concealment or misrepresentation of the patient's condition.

B.8.- Respondent's office note of September 11, 1996 was considered adequate in documenting that the risks of the resurfacing surgery were made known to the patient. In addition, the patient signed a consent form on the day of surgery in which she acknowledged that the risks had been explained. Inaccuracies in the office record were deemed to be unintentional.

B.9.- The Committee found the testimony of Respondent's former office manager to be credible and concluded that Respondent personally failed to properly calibrate the laser equipment prior to its use on Patient B in September, 1996. Such a failure was determined to be practice of the profession with negligence and incompetence.

B.10.- Sustained as to practicing the profession fraudulently and with conduct evidencing moral unfitness. See Conclusions of Law and Discussion related to Factual Allegation R, below.

B.11.- Patient B was found to have credibly testified about her pain and discomfort following the laser resurfacing surgery. It was very clear that she continued to express her complaints to Respondent and that he did not appropriately respond to, or document, those complaints. The inadequate actions can not be rationalized as a simple difference of opinion. It should have been apparent to Respondent that Patient B experienced complications from the surgery which necessitated treatment which was not provided. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

B.12. and B.13- The failure of Respondent to appropriately follow-up clear indications of an infection and to obtain the results of the culture obtained from the patient were determined to be acts of practice of the profession with negligence and incompetence.

B.14.- The Committee concluded that the Department did not establish by a preponderance of the evidence whether Respondent made the statement to the patient and did not sustain this Factual Allegation.

FINDINGS RELATED TO PATIENT C

23. Patient C, a 38 year old female, was first seen in Respondent's office on October 1, 1998. She was interested in a consultation for breast reduction, correction of a deviated septum

and a tummy tuck. (Ex. 12, pp. 121-123; T. 389-90)

24. The consultation reports prepared by Respondent incorrectly documented that Patient C had overall physical and mental embarrassment about the deformity of her nose, that vital signs were taken and a patient education videotape shown, a diagram of the proposed rhinoplasty was drawn, treatment for her difficulty in breathing was asked and different options for performing the breast reduction surgery were discussed. (Ex. 12, p. 121; T. 397-8, 401-2)

25. The patient had a pre-operative history and physical performed by a nurse on December 30, 1998. Respondent did not perform and was not present for this history and physical. A separate history and physical examination form signed and dated by Respondent on December 30, 1998 and signed by Respondent a second time on January 6, 1999 was in the St. Elizabeth Hospital chart. Respondent had rexamined the patient pre-operatively and signed the form on the day of surgery. (Ex. 12, pp. 112-3, Ex. 14, pp. 19-20; T. 414-19, 1617-19, 2217-2218)

26. Respondent documented his surgical plan for the January 6, 1999 procedures in a note in the hospital record on the same date. (Ex. 14, p. 21)

27. On January 6, 1999, Respondent performed a bilateral reduction mammoplasty, suction assisted lipolysis of both outer thighs, abdominal wall reconstruction with abdominoplasty, and reconstructive rhinoplasty on Patient C. There was inadequate documentation in the patient's medical record of an indication for the rhinoplasty. (Ex. 12, pp.86-7)

28. The reduction mammoplasty was done by the Lejoure technique. This technique is considered an evolutionary change in procedure in that it is one that is merely a modification of existing procedures. (T.2453-5)

29. Within a few days after the surgery, the patient observed that both nipples were very high, they were not symmetrical and that she had a lump of extra tissue under her right breast. The nipple/areolar complex should be at the level of the inframmary fold; Respondent's surgery placed the complex substantially above the fold. (Ex. 13, pp. 23-30; T. 430-431, 1574-5)

30. During multiple post-operative visits Patient C continued to tell Respondent that she wanted corrective breast surgery. (T. 437).

31. Respondent's record does not accurately state complaints and condition of the patient post-operatively in that he wrote in several notes that the patient was healing well without complaints pain or discomfort from the reduction mammoplasty surgery; she was actually in great discomfort and not satisfied with her recovery. (Ex. 12, p. 59; T. 430-7)

32. Respondent performed a breast lift, nipple and scar revision on the patient on February 24, 1999. No pre-operative evaluation examination, treatment plan or consultation with Patient C concerning this surgery was documented and an operative report for the procedure was not prepared. The patient signed an informed consent on the day of surgery. (Ex. 12, pp. 47-55)

33. Respondent recorded a note in the patient's medical record indicating that he planned additional scar revision surgery for this patient in April, 1999 without documenting findings or a plan. (Ex. 12, p. 42)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT C

The Committee **SUSTAINED** Factual Allegations C.1., C.4., and C.6.through, and including, C.9. All other Factual Allegations related to Patient C were **NOT SUSTAINED**.

C.1.- Respondent's use of "templates", or standardized forms, received substantial attention during this proceeding. The Committee found no fault with the use of these forms as a guide to be expanded

upon in the medical record; however, Respondent utilized the templates as a substitute for the record itself. It also was clear that the canned language of the initial consultation forms did not reflect the reality of the care and treatment rendered by Respondent and merely served as time-saving shortcuts. The Committee determined that Respondent knew that the information on the templates was inaccurate and that it was prepared to lead other persons to conclude that evaluations had been performed when they actually had not. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

C.2. and C.3. - The Committee found Respondent's explanation acceptable concerning documentation of the December 30, 1998 history and physical examination and the January 6, 1999 pre-operative assessment. He noted no change from the nurse's earlier findings on the day of Patient C's surgery.The Committee also concluded that Respondent documented an adequate assessment and plan in the note in the hospital record.

C.4.- There was an inadequate indication for the performance of the reconstructive rhinoplasty. The Committee considered Respondent's preoperative photographs (Ex. 13) did not justify the procedure. This was considered to be practice of the profession with negligence.

C.5.- The Committee agreed with the testimony of Respondent's expert that the Lejoure method of reduction mammoplasty was a modification of existing surgical procedures that did not require significant additional training.

C.6.- The testimony of the Department's expert and Respondent's own post-surgical photographs were relied on to clearly establish an improperly performed reduction mammoplasty in that the nipple/areolar complex was placed too high on Patient C's breast. The poor results supported the finding that Respondent performed the surgery in an incompetent manner reflecting an absence of skill.

C.7.- The patient credibly testified about the post-surgical complications she experienced, which were inaccurately documented in her medical record. The Committee believed Respondent intended to mislead as to the results of the surgery and determined the post-operative treatment constituted the practice of medicine with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

C.8.- Respondent failed to adequately document what procedures were performed during the February 24, 1999 revision surgery. The patient's consent to the surgery and brief nurse's note were inadequate, in the absence of any operative report, in establishing the actual purpose of the procedures. Specifications of practicing with negligence and incompetence were sustained.

C.9.- The Committee sustained this Allegation as being factually accurate, but not constituting professional misconduct. A rationale for additional surgery may have been documented in the future had the patient remained under Respondent's care.

FINDINGS RELATED TO PATIENT D

34. Patient D, a 51 year old female, first consulted with Respondent on June 7, 2000 for treatment for varicose veins by sclerotherapy. At the same office visit, Respondent also provided a consultation for repair and restoration of her eyelids. (Ex. 18, pp.131-3)

35. The consultations reports prepared by Respondent incorrectly documented significant information including: the patient's relevant history, that he told her of the risk of blindness, asked her about medications related to mood elevation or psychiatric conditions, took her vital signs and demonstrated computer graphic imaging. (Ex. 18, pp.130-1)

36. On June 29 and July 5, 2000, Patient D had sclerotherapy injections in her legs by Respondent to eliminate the varicose veins. There is no documentation of such injections on either day in the patient's medical record. (Ex. 18, p.125; T. 316, 321, 1713-5)

37. On July 31, 2000, Respondent performed a forehead lift, left lower blepharoplasty, mid-face lift and neck transfixtion suture, chin implant and lipo injection on Patient D. (Ex. 18, pp. 103-4)

38. Respondent placed the chin implant through the oral route, instead of placing it submentally, or under the chin, despite noting in the record that the patient's dental hygiene was poor. (Ex. 18, pp. 103-4; T. 1553)

39. On September 29, 2000, Respondent failed to prepare an operative report for removal of the chin implant and replacement with another. (Ex. 18, pp. 97, 99; T. 1523)

40. On October 9, 2000, Respondent replaced the second implant and took a culture because of the presence of an infection. An operative report for this procedure, incorrectly dated September 29, 2000, was prepared, as was a pre-operative nursing note. (Ex. 18, pp. 91, 95-6)

41. On December 22, 2000, the patient signed consent forms for fat injections, browlift surgery and $C0_2$ laser treatment of the skin. A preoperative evaluation, history and physical examination were performed and documented. However, Respondent prepared no operative report for the procedures performed on December 26, 2000. (Ex. 18 pp.71-88; T. 1735)

42. Respondent's record does not accurately state complaints and condition of the patient post-operatively in that he wrote in several notes that the patient was healing well without complaints of pain or discomfort, when she was actually in great discomfort and not satisfied with her recovery. (Ex. 18, pp. 95, 100, 102; T. 325-7, 329-37)

43. Respondent prepared an undated note in Patient D's medical record which falsely indicated that he performed a glycolic acid peel on her face. (Ex. 18, p.52: T. 340)

44. An office entry made by the Respondent dated February 1, 2001 noted statements made by the patient concerning certain personal matters. (Ex. 18, p. 62)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT D

The Committee **SUSTAINED** Factual Allegations D.1., D.2., D.3., D.4. and D.6. in part, and D.7.through, and including, D.9. All other Factual Allegations related to Patient D were **NOT SUSTAINED**.

D.1.- As discussed above, the Committee considered Respondent's use of templates to create a medical record with little, or no, individualized information to be inadequate and inappropriate. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

D.2.- The patient credibly testified that Respondent, on two different office visits, administered injections into her legs as treatment for her varicose veins. The absence of any documentation of these treatments was considered to be practice of the profession with negligence.

D.3.- The Committee determined that Respondent's failure to place the chin implant submentally during the July 31, 2000 surgery, after documenting her poor oral hygiene, did not meet acceptable medical standards and constituted practice of the profession with negligence.

D.4.- The Committee considered the nurse's preoperative notes for the September 29, 2000 procedure to be an adequate evaluation of the patient. The operative note dated September 29, 2000 was considered to most likely be inaccurately dated, as asserted by Respondent, and to actually represent the report for the October 9, 2000 procedure. Therefore, no operative report was prepared for the September 29, 2000 treatment, an omission determined to be practice of the profession with negligence.

D.5.- The nurse's note dated October 9, 2000 was considered an adequate preoperative evaluation for the procedures performed on that day.

D.6.- Again, the nursing notes of a preoperative evaluation, history and physical examination were considered to be appropriate for the treatment rendered on December 26, 2000. However, the absence of an operative report made it impossible to determine which of the several procedures consented to by Patient D were actually performed. This omission was determined to be practice of the profession with negligence.

D.7.- The patient credibly testified about the post-surgical complications she experienced, which were inaccurately documented in her medical record. She clearly was experiencing pain and was not "doing well" as the Respondent often noted. The Committee believed Respondent intended to mislead as to the results of the surgery and determined the post-operative treatment constituted the practice of medicine with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

D.8.- The patient credibly testified that she did not ever undergo a glycolic acid peel. Respondent's documentation of such treatment was undated and he testified that he believed it was performed on the day of Patient D's first surgery on July 31, 2000. The Committee believed Respondent's note to be false and found no purpose for such treatment on July 31, 2000, even if it had been provided. The preparation of this note constituted the practice of medicine with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

D.9.- The Committee found this Allegation to be factually accurate, and observed that the note in question was one of the few found in Respondent's own handwritting. Although the patient denied the veracity of the charted note, the Committee chose to not speculate as to the basis for its inclusion in her medical record and did not consider it to constitute misconduct.

FINDINGS RELATED TO PATIENT E

45. Patient E, a 42 year old female, consulted with Respondent on March 19, 1998 for an abdominoplasty. (Ex.21, p. 97)

46. Respondent provided a consultation on March 19, 1998 for augmentation mammoplasty and liposuction in addition to an abdominoplasty. His report for the breast augmentation procedure inaccurately documented that Patient E stated that she had low self esteem because of her breast size, had been thinking about surgery for a long period of time, had been wearing wonder bras and/or padded bras, was unhappy because of her breast size, and that measurements were taken of the location of the breasts in relation to the suprasternal notch. Respondent never examined the patient with her clothing off to visualize her breasts. (Ex. 21, p. 93; T. 202-205, 283)

47. Respondent's consultation report for liposuction inaccurately documented that the patient had been thinking about liposuction for a prolonged period of time, that she had lipotamous accumulations resistant to dieting and exercising, that she was shown videotapes, that computer graphic imaging was demonstrated, and that the length and duration of the problem was noted in the chart. (Ex. 21, p. 94; T. 207-209)

48. Prior to the initial consultation, Respondent provided to Patient E a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.A.C.S., F.I.C.S." which falsely represented that he completed a fellowship at Lenox Hill Hospital, was a member of the American Society of Plastic and Reconstructive Surgeons, and the North Eastern Society of Plastic Surgeons. (Ex. 25; T. 194-5)

49. Respondent sent Patient E a letter dated May 4, 1998 which scheduled her for surgery and which contained a heading of the symbol and name of the American Society of Plastic and Reconstructive Surgeons. Respondent had received a letter from the American Society of Plastic

and Reconstructive Surgeons dated March 4, 1996 which informed him that he had not satisfied the Society's requirements for Active Membership and that his name was therefore removed from the list of Candidates for Membership. (Ex. 6, p.56, Ex. 52, p.80, Ex. 21 p.80; T. 212-13)

50. On May 8, Respondent performed breast augmentation, liposuction of the upper abdomen, lower abdomen and flanks and abdominoplasty on Patient E. (Ex. 21, pp.53-54)

51. Respondent's consultation for augmentation mammoplasty states the implants would be placed in the submammary position. The pre-operative checklist indicated that the patient wanted the implants submuscular. The consent form for the procedure which Patient E signed provided that the positioning of the implants depended on the patient's' preferences, anatomy and surgeon's recommendation. During the May 8, 1998 operation, Respondent placed the patient's implant in the submuscular position (Ex. 21, pp. 53, 64, 71, 93)

52. The combination of full abdominoplasty with upper abdominal liposuction did not meet acceptable standards of care because of the interruption of blood supply to the distal (lower) flap of the abdominoplasty, thereby increasing the potential risk of loss of tissue. An abdominoplasty and extensive liposuction performed separately would be acceptable; the standard of care is not to do them together (T. 887-9, 907-908)

53. Following the procedure, Patient E had fluid which solidified in the upper part of her abdomen. Respondent noted, in an entry dated July 30, 1998, a golf ball size lump in her lower sternum. He described it as a "fatty clump" or "mass" and considered it to be fat necrosis. (Ex. 21, pp. 46; T. 219-20, 1302-3)

54. On November 11, 1998, the patient was seen at Respondent's office for a pre-operative visit and signed a consent for liposuction fat necrosis of the abdomen, revision dog ear on the right abdominal incision, umbilicus revision and closed capsulotomy bilaterally breast. (Ex. 21, pp. 36-40; T. 234-7; 893-894)

55. Respondent's operative note for November 23, 1998 reported that he only performed a syringe liposuction of the upper abdomen. Syringe liposuction is removal of the destroyed fat with a syringe. It was not appropriate for Respondent to have attempted to treat the hematoma in the patient's upper abdomen by liposuction (Ex. 21, p.32.; T. 896, 899-900)

56. The nursing note reflected that Respondent also performed an open capsulotomy bilateral breast, liposuction revision upper abdomen, umbilicoplasty and revision right abdominal scar. Respondent's operative report failed to reflect everything that took place in the operating room, including alteration of the location of the patient's implants and revision of the dog ear of the right abdominal incision. (Ex. 21, pp. 32-3)

57. The patient did not sign a consent for an open capsulotomy; consent to a closed capsulotomy would not constitute consent for an open capsulotomy. Respondent did not note in his record any condition that would warrant performing a closed capsulotomy on November 23, 1998. (T. 2502-2503).

58. Patient E did not have fat necrosis. Fat necrosis is part of the procedure in liposuction: a localized accumulation of fat necrosis would be unusual and would lead to the presumption that it was blood. The hematoma would not be there as a fluid after six months; it would have become scar tissue. (T. 921-2)

59. Respondent's record for Patient E does not accurately state complaints and condition of the patient post-operatively in that he wrote in several notes that the patient was healing well without complaints of pain or discomfort, when she was actually in great discomfort and not satisfied with her recovery. (Ex.21, pp.42, 44-52; T. 220-33)

60. Notes in the patient's chart indicate Respondent had proposed further surgery for Patient E to take place in January, 1999. There was no documentation of a history, physical examination, or treatment plan for further surgery. (Ex.21, p.27)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT E

The Committee **SUSTAINED** Factual Allegations E.1., E.2., E.3., and E.5.through, and including, E.10. All other Factual Allegations related to Patient E were **NOT SUSTAINED**.

E.1.- As discussed above, the Committee considered Respondent's use of templates to create a medical record with little, or no, individualized information to be inadequate and inappropriate. Much of the information contained in the consultation reports was false. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

E.2 and E.3.- Sustained as to practice of the profession fraudulently, and in a manner evidencing moral unfitness. Factual Allegation E.2. was also found to be advertising not in the public interest. See Conclusions of Law and Discussion related to Factual Allegations R and V, below.

E.4.- The preoperative checklist noted the patient's choice to have the breast implants placed in the submuscular position. While it was observed that this note conflicted with Respondent's consultation report, the Committee considered the language of the consent signed by Patient E in not sustaining this Allegation.

E.5.- The Committee relied on the testimony of the Department's expert that the performance of an abdominoplasty and abdominal liposuction in combination did not meet accepted standards of practice. Respondent's surgery was determined to be practice of the profession with negligence and incompetence.

E.6.- The Committee believed that the patient's abdominal mass may not have been a hematoma and was more likely scar or muscle tissue than fat necrosis. Respondent testified that it was a solid mass. The Committee members did not believe that such a mass could be removed by liposuction and that Respondent's treatment was therefore inappropriate. A specification of practice of the

profession with incompetence was sustained.

E.7.- The operative report prepared by Respondent differed from the nursing note as to what procedures were actually conducted on Patient E on November 23, 1998. It was clear that more than a syringe liposuction of the upper abdomen was performed. The operative report was inaccurate and inadequate and was found to represent practice of the profession with negligence and incompetence.

E.8.- The Committee noted a reference to the repair of diastasis recti in Respondent's operative report for the patient's May 8, 1998 surgery and considered that as an indication that the abdominal mass was something other than fat necrosis, such as scar or muscle tissue. The misdiagnosis was found to constitute practice of the profession with incompetence.

E.9.- The patient credibly testified about the post-surgical complications she experienced, which were inaccurately documented in her medical record. She clearly was experiencing pain and was not "healing" or "doing well" and was not satisfied as the Respondent often noted. The Committee believed Respondent intended to mislead as to the results of the surgery and determined the post-operative treatment constituted the practice of medicine with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

E.10.- The Committee sustained this Allegation as being factually accurate, but as not constituting professional misconduct. A rationale for additional surgery may have been documented in the future had the patient remained under Respondent's care.

FINDINGS RELATED TO PATIENT F

61. Patient F, a 50 year old female, first consulted with Respondent on December 27, 2000 for certain cosmetic procedures for her face, eyelids, neck, buttocks, hips and abdomen. (Ex. 26, p.99; T. 562)

62. Respondent's consultation report for aging face falsely documented that he had asked the patient about prior treatment for her facial condition and about changes in her face, that she was shown a videotape and that she was administered vision tests. Respondent's consultation report for liposuction with abdominoplasty falsely noted that he asked about previous treatments concerning accumulations of fat in her body and that she was shown a videotape. (Ex.26, pp. 90-1; T. 564-70)

63. Patient F informed Respondent that she had a history of one kidney and that she had a large scar on her left side. Respondent conducted no preoperative evaluation to assess the patient's renal function. The fact that a patient has only one kidney would not preclude elective surgery; however testing should be performed to assess the patient's renal function and also to determine if the patient has bacteria in the urinary tract. (T. 1391-1393)

64. Respondent stated to Patient F that, after her surgery, "you're going to be beautiful", and that he was, "the best". (T. 570)

65. Patient F signed an informed consent for an abdominoplasty surgery which set out potential adverse results from smoking. A preoperative history dated January 3, 2001 indicated that the patient smoked. Respondent did not perform liposuction of the upper and lower abdomen on the patient because of his concerns about her smoking. (Ex. 26, pp. 61, 76, 86-7; T. 1802-4)

66. Respondent performed an abdominoplasty, bilateral upper and lower blepharoplasty and liposuction of the flanks, inner and outer thighs and lateral knee on Patient F on January 5, 2001. Respondent prepared two operative reports for the surgery performed on that date which listed different anesthesiologists. Both operative reports stated that the patient had no drains; in fact, the patient had Jackson Pratt drains in her abdomen. (Ex. 26, pp. 36-41, Ex. 28; T. 577-578

67. On January 24, 2001 Patient F was prescribed Bactrim DS by Respondent in response to complaints of frequent urination, lower back pain and bladder pressure. The patient had a history of urinary tract infections. (Ex. 26, p.34; T. 581-582)

68. On January 30, 2001, the patient presented to Respondent's office with the complaint that she could not close her right eye. The patient signed a consent for a revision of the right eyelid to be performed by Respondent on that day. (Ex. 26 at 16, 27; T. 586-7)

69. Respondent inappropriately failed to document an evaluation of the patient before the January 30, 2001 surgery. Respondent appeared to write notes over nursing notes on that day in the patient's record; his writings were indecipherable. Respondent also did not create an operative note for the surgery he performed on the patient's eye on January 30, 2001 and it is not possible to know what procedure was actually performed. The appropriate procedure to address the patient's complaint of a pulling down of the lower eyelid was a skin graft, which Respondent failed to perform. (Ex. 26, pp. 15-7; T. 1397-1402, 1406-7)

70. The patient's current condition is that she has a bunch in her abdomen and a vertical mark from her belly button to her pubic bone; the scar on her abdomen remains painful. (T. 597, 628-30)

71. At her final visit in early March, 2001, Respondent proposed another surgery to correct her eyelid. Respondent did not document in the chart that he had proposed a third surgery to the patient. (T. 589-590)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT F

The Committee **SUSTAINED** Factual Allegations F.1., F.2., F.3., F.5., in part, and F.7.through, and including, F.10. All other Factual Allegations related to Patient F were **NOT SUSTAINED**.

F.1.- As discussed above, the Committee considered Respondent's use of templates to create a medical record with little, or no, individualized information to be inadequate and inappropriate. Much of the information contained in the consultation reports was false. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

F.2.- The failure of Respondent to document any preoperative evaluation of the patient's renal function, in light of her history of having only one kidney, was determined to be practice of the profession with negligence and incompetence. The absence of such documentation created a presumption that the patient's history was never considered by Respondent when determining whether surgery would be an appropriate option.

F.3.- This Allegation was sustained as being factually accurate, but was not determined to rise to the level of professional misconduct.

F.4.- The record contained substantial evidence that the patient was informed of the risks associated between smoking and plastic surgery and that she chose to proceed with the surgery. Respondent did not perform certain procedures because of Patient F's smoking. This Allegation was not sustained.

F.5.- The operative note of January 5, 2001 was clearly inaccurate in documenting that no drains were inserted in the patient's abdomen. The Committee considered that the inaccuracy and creation of two operative reports was not the result of an attempt to mislead or to misrepresent the patient's condition and found that the incorrect note represented practice of the profession with negligence and incompetence.

F.6.- The failure to take a urine sample prior to prescribing Bactrim DS for the patient was not considered to be improper, based on the patient's history of urinary tract infections.

F.7.- Respondent's surgery on Patient F on January 30, 2001 represented practice of the profession with negligence and incompetence in that he recorded an inadequate preoperative evaluation of the patient and documented no operative report. It could not be determined exactly what procedures were performed on that day. The Committee believed that a skin graft should have been performed to address the patient's complaint of a pulling down of the lower eyelid.

F.8.- It was not possible to read notes written by Respondent in the patient's chart in entries dated January 30, 2001. This was determined to constitute practice of the profession with negligence.

F.9- The patient credibly testified about the post-surgical complications she experienced, which were inaccurately documented in her medical record. She clearly continued to experience pain and had additional abdominal scarring. These post-surgical complications were not adequately documented in her record or addressed by Respondent. The Committee believed he intended to mislead as to the results of the surgeries and determined that the post-operative treatment constituted the practice of medicine with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

F.10.- The Committee sustained this Allegation as being factually accurate, but as not constituting professional misconduct. A rationale for additional surgery may have been documented in the future had the patient remained under Respondent's care.

FINDINGS RELATED TO PATIENT G

72. Patient G, a 27 year old African-American female, was first seen at Respondent's office on October 24, 2001 for a consultation about hair removal from her chin. (Ex. 30, pp. 11-2)

73. Respondent's consultation note did not indicate that the patient was African American, a significant factor in considering laser treatment, and did not indicate in what area of the body the unwanted hair was located. The report incorrectly stated that vital signs were taken and areas of unwanted hair were marked, when they were not. (Ex. 30 at 11, T. 1920)

74. A test patch to test for depigmentation was performed on the patient, but the results were not documented in the chart. (Ex. 30, p.1)

75. Laser treatment to remove the hair was performed on October 29, 2001 on Patient G by a Registered Nurse who was an employee of Respondent. Patient G signed a consent form on that day authorizing that the procedure be performed by Respondent or medical staff. The operative note for the procedure did not indicate who actually performed the treatment. (Ex. 30, pp.5, 9)

76. The patient came to Respondent's office on the following day with complaints of blistering on her chin. She was told he was out of town and unavailable, was provided an ointment to apply to the affected area and was scheduled for an appointment to see Respondent on November 5, 2001. (Ex. 30, p.9; T. 161-3)

77. Patient G was seen by her family physician on October 31, 2001. She was noted to have an area of blistering and hyperpigmentation with skin peeling of about five inches in length and was assessed as having a second degree burn with an open wound. (Ex. 32, p.2)

78. At her appointment on November 5, 2001, Respondent's staff again said he was out of town and unavailable. She therefore returned on November 14, 2001 and saw Respondent, who denied that the patient had a burn. (T. 166-7)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT G

The Committee **SUSTAINED** Factual Allegations G.1., G.3., G.5., and G.6. All other Factual Allegations related to Patient G were **NOT SUSTAINED**.

G.1.- As discussed above, the Committee considered Respondent's use of templates to create a medical record with little, or no, individualized information to be inadequate and inappropriate. Much of the information contained in the consultation reports was false. There was no indication

in the consultation report of the location of the unwanted hair that the patient wanted removed. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

G.2.- The Committee considered the Registered Nurse who performed the procedure to be a member of Respondent's medical staff and did not sustain this Allegation.

G.3.- The failure to document the result of the test patch for depigmentation was determined to be evidence of practicing with negligence and incompetence. If the result was "normal", as testified to by Respondent, it should have been documented.

G.4.- Respondent used poor diligence in screening Patient G as an appropriate candidate for laser treatment. However, the Committee concluded that the laser treatment was performed correctly from a technical viewpoint and did not sustain the Allegation.

G.5.- The notation of the technician performing the treatment on the preoperative checklist was considered to be inadequate documentation. The failure of the operative report to indicate who actually performed the treatment was determined to be practice of the profession with negligence and incompetence. The Committee believed that the inadequate operative report reflected Respondent's poor recordkeeping practices and was not evidence of an intent to mislead or misrepresent the treatment provided.

G.6.- Patient G's primary physician diagnosed a second degree burn two days following surgery. Unlike Respondent's records, the primary physician's examination and evaluation of the patient was well documented. The Committee considered Respondent's denial of this diagnosis, which he maintained in his testimony about his treatment of Patient G, to be evidence of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

FINDINGS RELATED TO PATIENT H

79. Patient H, a 25 year old African American female, first consulted with Respondent's staff on July 12, 2000 for hair removal around her chin, cheeks and upper lip. (Ex. 33, p.1)

80. Respondent's consultation report incorrectly stated that the patient's hair problem started at puberty, that she was told of risks of scarring and that the consultation was performed by Respondent. Patient H never met Respondent until after surgery was performed. (Ex. 33, p.1; T. 646-7)

81. The consent form signed by the patient authorized that lasertrolysis be performed by Respondent or medical staff. Laser surgery was performed on August 4, 2000 by a Registered Nurse employed by Respondent. (Ex. 33, pp. 3, 9)

82. The operative report for the procedure falsely listed Respondent as the surgeon when, in fact, he was not present at the surgery. (Ex. 33, p.9)

83. The patient believed that the August 4, 2000 procedure did not achieve her desired result and she returned to Respondent's office on September 15, 2000 for a second laser treatment. The laser setting was adjusted to a higher level and Patient H received burns or scarring to her face. (Ex. 33, pp. 10-11; T. 651-3)

84. Patient H returned for a follow-up visit on September 22, 2000 and was seen by a nurse. The patient was noted to have hypopigmented areas on the left side of her face and was provided hydrocortisone as treatment for that condition. She was not seen by Respondent on that day. (Ex. 33, p.11; T. 664)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT H

The Committee **SUSTAINED** Factual Allegations H.1., H.2., in part, H.3., and H.5. All other Factual Allegations related to Patient H were **NOT SUSTAINED**.

H.1.- The consultation report was another example of Respondent's use of a template which inaccurately listed patient history and the treatment and care rendered. The report falsely indicated that Respondent met with the patient on July 12, 2000. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

H.2.- The Committee sustained the portion of this Allegation relating to Respondent's failure to document the patient's complications following the second laser treatment. There was no evidence he ever saw the patient and evaluated her condition. A Specification of practice of the profession with negligence was sustained.

H.3.- The operative report for the August 4, 2000 procedure inaccurately indicated that Respondent performed the surgery, when he did not. The Committee did not consider the incorrect information to represent an intent to mislead and felt it represented practice of the profession with negligence and incompetence. It was also noted that the operative reports for Patients G and H, both of whom received laser treatments for removal of facial hair, were virtually identical. The only minor differences in the reports were generic and were not patient specific.

H.4.- The Committee considered the Registered Nurse who performed the procedure to be a member of Respondent's medical staff and did not sustain this Allegation.

H.5.- Respondent's failure to evaluate the patient's complaints on September 22, 2000 was determined to be practice of the profession with negligence. Unlike his testimony concerning the burn received by Patient G, Respondent did not deny that Patient H was burned by the laser treatment. The Committee concluded that there was no intent to misrepresent Patient H's condition.

FINDINGS RELATED TO PATIENT I

85. Patient I, a 20 year old female, first consulted with Respondent on October 11, 1999 for a discussion about breast augmentation surgery. (Ex. 36, p.46)

86. Respondent's consultation report for augmentation mammoplasty incorrectly stated that the patient had been wearing wonder bras and padded bras, that the decision had been made to place the implants in the submammary position, that the patient's breasts were measured, and that vital signs were taken. (Ex. 36, p.46; T. 517, 522-523)

87. Respondent performed augmentation mammoplasty on Patient I on October 21, 1999. He prepared two different operative reports for this procedure; one stated that the implants were placed in the submuscular position, the other stated that they were placed in the submammary position. Different anesthesiologists were listed on each report. The operative reports also falsely stated that computer imaging was shown to the patient. (Ex. 36, pp.25, 27; T. 531)

88. Patient I presented with a contour or "double bubble" under her breasts when she was seen in Respondent's office in October of 1999 for follow up visits. This was created by a violation of the patient's inframammary fold, which is the fold of tissue where the breast and chest wall meet. If the fold is violated the prosthesis will fall beneath the fold, resulting in the double bubble by forming a band across the prosthesis. The improper positioning of the implant in relation to the overlying breast is a recognized complication of this surgical procedure. (Ex. 38; T. 536- 537, 1466, 1506, 2532-3)

89. Respondent did not document in the patient's chart that she had the complication of a double bubble. Respondent did not make any notes related to the patient's post-operative visits and failed to assess her condition when she reported to the office post-operatively with complaints of pain. (Ex. 36, pp. 20-4; T. 534)

90. Respondent performed a closed capsulotomy on the patient on November 16, 1999. A closed capsulotomy is a way of breaking scar tissue by gathering the breast and prosthesis in the physician's hands and then squeezing them to break the scar. An attempt can then be made to try to manipulate the prosthesis lower. (Ex. 36, p.22; T. 1469, 1502-1503).

91. Respondent proposed surgery to place larger implants for Patient I at her final visit with him on January 24, 2000 for the purpose of eliminating the double bubble without documenting findings, an assessessment or a treatment plan. (Ex. 36, p. 20; T. 539)

92. Patient I was an exotic dancer when she met Respondent. At some time during his course of treating her, Respondent asked Patient I if she would give him a free dance if he came to the club where she was employed. (T. 514, 539)

93. In sworn testimony in a suit brought by Patient I, Respondent testified on June 21, 2001 that during the first visit as he examined her breasts, the patient stated that she wanted to have the implants under the muscle, that he warned the patient her chances were very high she would need revision surgery, and that he told the patient that implanting in the subglandular position was a better approach, but that an attempt could be made to place the implants under the muscle, provided she understood that she could need revision surgery in the future. (Ex. 39, pp.25-6, 36-7; T. 540)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT I

The Committee **SUSTAINED** Factual Allegations I.1., I.3., I.5. and I.6. All other Factual Allegations related to Patient I were **NOT SUSTAINED**

I.1.- As discussed above, the Committee considered Respondent's use of templates to create a medical record with little, or no, modification to reflect individualized information to be inadequate and inappropriate. Much of the information contained in the consultation reports was false. Specifications of practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness were sustained.

I.2.- The Committee determined that the Department did not meet its burden of proof to establish by a preponderance of the evidence that Respondent made the alleged statements. This Allegation was not sustained.

I.3.- The two operative reports with differing information made it impossible to determine where the breast implants were actually placed. If the second report was intended to correct errors contained in the first, some notation reflecting that fact should have been recorded. As with other recordkeeping deficiencies, the Committee did not conclude that Respondent intended to misrepresent the patient's condition and found the creation of the two operative reports to be practice of the profession with negligence and incompetence.

I.4.- The Committee accepted Respondent's expert's testimony that the creation of a double bubble effect in breast augmentation surgery is a known complication that can occur. There was no conclusion that Respondent inappropriately placed the implants or used an improper size.

I.5.- The failure to document Patient I's post-surgical complications was inexcusable and was considered to be practice of the profession with negligence and incompetence, practicing fraudulently and with conduct evidencing moral unfitness.

I.6.- The patient credibly testified that Respondent made the inappropriate comment to her. Respondent's action was not considered to constitute professional misconduct.

I.7.- The Committee believed that Respondent did have the requisite understanding and knowledge to correct the patient's complication. Instead, the Committee found fault with his lack of judgement and poor recordkeeping practices in this case. This Allegation was not sustained.

I.8.- The Committee sustained this Allegation as being factually accurate, but as not constituting professional misconduct. A rationale for additional surgery may have been documented in the future had the patient remained under Respondent's care.

I.9.-I.11.- The Committee could not determine Respondent's intent in the statements he made to Patient I and the members did not feel they were in a position to evaluate testimony in a civil lawsuit. The three Allegations were not sustained.

FINDINGS RELATED TO PATIENT J

94. Patient J, a 29 year old female, first consulted with Respondent on March 15, 2000 for breast augmentation. (Ex. 40, p. 57)

95. Respondent performed breast reconstruction surgery on Patient J on March 28, 2000. His operative report documented a pre- and post operative diagnosis of fibrocystic disease. There was no documentation of physical findings in the medical record to support such a diagnosis. (Ex. 40, p. 36)

96. Respondent's consultation report indicated that breast implants would be placed in a submammary position. The operative report indicated that the implants were placed in the submuscular position. Respondent prepared no documentation in the medical record for the basis for the difference between the proposed and actual placement of the implants. (Ex. 40, pp. 36, 57)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT J

The Committee **SUSTAINED** Factual Allegations J.1.and J..2.

The Committee concluded that the absence of documentation for the clinical basis of a diagnosis of fibrocystic disease constituted practice of the profession with negligence and incompetence. The actual treatment for Patient J was not related to the diagnosis and there could therefore be no conclusion that the diagnosis was made with the intent to misrepresent or conceal the patient's condition.

The Committee further concluded that the absence of documentation for the basis for placing the implants submuscularly instead of in the position noted in his consultation report also constituted practice of the profession with negligence and incompetence.

FINDINGS RELATED TO PATIENT K

97. Patient K, an 18 year old female, first consulted with Respondent on December 22, 1998 for breast augmentation. (Ex. 41, pp.64-5)

98. Respondent scheduled breast reconstruction surgery on Patient K for December 29, 2000. A preoperative history and physical examination was performed and documented by a nurse employed by Respondent. (Ex. 41, pp.50-1)

99. His operative report documented a pre- and post operative diagnosis of fibrocystic disease. There was no documentation of physical findings in the medical record to support such a diagnosis. (Ex. 41, p.39)

100. Respondent's consultation report indicated that breast implants would be placed in a submammary position. The operative report indicated that the implants were placed in the submuscular position. Respondent prepared no documentation in the medical record for the basis for the difference between the proposed and actual placement of the implants. (Ex. 41, pp. 39, 64)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT K

The Committee **SUSTAINED** Factual Allegations K.2. and K.3. Allegation K.1. was **NOT SUSTAINED.**

The Committee considered the preoperative history and physical exam taken by the nurse to be adequate, notwithstanding Respondent's failure to co-sign and did not sustain Allegation K.1.

The Committee concluded that the absence of documentation for the clinical basis of a diagnosis of fibrocystic disease constituted practice of the profession with negligence and incompetence. The actual treatment for Patient J was not related to the diagnosis and there could therefore be no conclusion that the diagnosis was made with the intent to misrepresent or conceal the patient's condition.

The Committee concluded that the absence of documentation for the basis for placing the implants submuscularly instead of in the position noted in his consultation report also constituted practice of the profession with negligence and incompetence.

FINDINGS RELATED TO PATIENT L

101. On or about April 5, 2001, Patient L, a 26 year old female, signed informed consents authorizing Respondent to perform liposuction and scar revision surgery. (Ex. 42, pp.3-12)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT L

The Committee did **NOT SUSTAIN** Factual Allegations L.3. and L.4.

No testimony was received related to Respondent's care and treatment of Patient L. The Committee determined that there was insufficient evidence in the record to establish that Respondent failed to adequately evaluate the patient prior to surgery. The absence of an operative report from the patient's medical record did not establish that one was not prepared by Respondent.

FINDINGS RELATED TO NURSE M

102. Nurse M, a female about 26 years old in December, 2000, was a LPN employed by Respondent from December, 2000 until April, 2001. (T. 670-1)

103. In February and March, 2001, Respondent made several inappropriate comments of a sexual nature to Nurse M. (T. 677)

104. Nurse M saw Patient F at a follow-up visit on February 2, 2001 and wrote a note in the medical record that the patient had an open area in her abdomen with green and very reddened areas as well. (Ex. 26, p.17)

105. Nurse M believed that the wound appeared to be infected and asked Respondent to examine the patient. Respondent's opinion was that the area was not infected, but was actually exhibiting new tissue growth. (T. 672-3)

106. On February 9, 2001, Patient F returned for another follow-up visit and again was seen by Nurse M. She noted in the patient's record two open areas which Respondent debrided. (Ex. 26, p.17)

107. Respondent read Nurse M's February 2, 2001 chart entry and told her she should not have written such a note because he had told her that the patient's open areas were not infected. (T. 673-4)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO NURSE M

The Committee **SUSTAINED** Factual Allegations M.1. and M.2.

The Hearing Committee found Nurse M to be a credible witness and believed that Respondent did make the offensive sexual comments to which she testified. Making these statements was considered to be conduct evidencing moral unfitness in the practice of medicine.

The Committee also found Nurse M credible in her testimony that Respondent instructed her to not record her impressions of Patient F's condition. The misrepresentation of the post-surgical condition of Patient F was seen as consistent with Respondent's actions in his treatment of other patients. The Committee could find no motivation for Nurse M to inaccurately describe Patient F's condition in her note. It was also observed that Respondent debrided Patient F's wounds on February 9, 2001, which would confirm that necrotic tissue was present. Respondent also improperly failed to document his treatment of the patient on that day. The Committee considered Respondent's action in directing Nurse M to inaccurately document her assessment of the patient to constitute practice of the profession with gross negligence and incompetence, practicing

fraudulently and with conduct evidencing moral unfitness.

FINDINGS RELATED TO FACTUAL ALLEGATION PARAGRAPHS O, P AND Q

108. Respondent published on his website a document entitled "How to Choose a Qualified Plastic Surgeon, " on February 9, 2000 and other dates. This was unauthorized use of copyrighted materials of the American Society of Plastic Surgery (ASPS), formerly known as the American Society of Plastic and Reconstructive Surgeons (ASPRS). (Ex. 44)

109. In a letter to Respondent dated February 9, 2000, the counsel to the ASPS requested that Respondent immediately cease the use and distribution of the ASPS material and remove such material from his website. (Ex. 52, pp. 85-6)

110. In an Order by the U.S. District Court (N.D. Ill., Eastern Division), dated May 3, 2000, it was determined that Respondent had infringed on ASPS copyrighted materials. He was perpetually enjoined from continued use of such materials or from holding himself out as a member of the ASPS. (Ex. 44, pp.34-8)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPHS O, P AND Q

The Committee **SUSTAINED** Factual Allegations O, P and Q.

The Committee determined that Respondent's use of the copyrighted materials of the ASPS represented the practice of the profession fraudulently, conduct evidencing moral unfitness and advertising not in the public interest. Respondent's fraudulent intent was demonstrated by a lawsuit being necessary following his failure to comply with the demand letter of the ASPS counsel that he cease his illegal use. The Committee rejected any contention Respondent's use of those materials was based on his confusion as to whether he was an active member of the ASPS. The attempt to shift responsibility to the marketing company responsible for Respondent's

advertising was found equally unpersuasive. The Committee believed the copyrighted materials were used with the intent to deceive potential patients as to Respondent's credentials.

FINDINGS RELATED TO FACTUAL ALLEGATION PARAGRAPH R

111. Respondent applied to become a candidate member of the ASPRS, in or around June, 1987. (Ex. 52, pp. 57-60)

112. Respondent was sent a letter from the ASPRS, dated October 27, 1988, in which he was notified that he had been elevated to "Candidate for Active Membership" and that such Candidates were not members and could not use the name and symbol of the Society until Board certification (Ex. 52, p.63)

113. Respondent was notified in a letter from the ASPRS , dated April 7, 1992, that Candidates could be voted to Active Membership before Board certification, provided that Active Membership status would be held in abeyance until a Candidate provided notice of Board certification. (Ex. 52, p.68)

114. Respondent became Board certified in plastic surgery in 1995 (Ex. C)

115. By letter from the ASPRS dated March 4, 1996, Respondent was notified that it had been determined that he had not demonstrated that he met the qualifications for Active Membership in the Society. He was further advised that his name would be removed from the list of Candidates for Active Membership and could that he could reapply in three years. (Ex. 52, p.80)

116. Respondent was entitled to claim membership in the Society and use their name and symbol between the period when he became Board certified in 1995 and March, 1996. (Ex. 52, pp.68, 80, Ex. C)

117. Respondent falsely claimed membership in the ASPRS in the following manner when he was not a member, and during a period other than between 1995 and March 1996:

a. In a 1988 application to the Medical Liability Mutual Insurance Company. (Ex. 45, p.7)

b. In a 1988 application to Little Falls Hospital. (Ex. 46, p.4)

c. In a 1990 application to St. Elizabeth, Faxton and St. Luke's Hospitals. (Ex. 59 at 31, 36)

d. In the Directory of the Medical Society of the State of New York for 1993-1994. (Ex. 47)

e. In a 1994 application to Little Falls Hospital. (Ex. 46, pp.17, 26)

f. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S.". (Ex. 25, Ex. 56, Tab 1)

g. In a document entitled "Pankaj T. Desai, M.D. Curriculum Vitae" (Ex. 52, p. 96, Ex. 56, Tab 14)

h. In documents dated June 25 and July 31, 1996, concerning Patient O. (Ex. 53)

i. In a document dated January 24, 1997, concerning Patient P. (Ex. 54)

j. In a document dated May 19, 1997, and in another undated document concerning Patient Q. (Ex. 55)

k. In the Directory of the Medical Society of the State of New York for 1997-1998. (Ex. 48)

l. In an application in 1999, to St. Joseph's Hospital Health Center, and in an attached document entitled "Training and Degrees". (Ex. 56, Tab 1, p.13)

m. In an application in 1999, to St. Joseph's Hospital Health Center, and in an attached document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S." (Ex. 56, Tab 1, p.15)

n. In a document dated around June 1999, concerning Patient R. (Ex. 57)

o. In a 1999 application to Oneida Healthcare. (Ex. 58, pp. 5, 23, 27)

p.. On or around February and March, 2000, and other dates, on his website, www.dr-desai.com (Ex. 52, pp. 88-91,192, Ex. 44, Attachment B)

q. In a brochure available in his office on May 10 and/or August 3, 2000, entitled "Pankaj T. Desai, M.D. Curriculum Vitae". (T. 702).

r. In the Directory of the Medical Society of the State of New York for 1999-2000. (Ex. 49)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPH R

The Committee **SUSTAINED** all Factual Allegations contained in Paragraph R.

The instructions in the letters from the ASPRS were considered to be clear and unambiguous. Respondent was never more than an Active Candidate for Society membership until his Board certification in 1995. As only a candidate for membership, he could not use the name or symbol of the Society. He may have been able to represent himself as a member from his Board certification in 1995 until his notification in March, 1996 that he was no longer considered a Candidate for Active Membership. He continued to hold himself out as a member for years after the March, 1996 notification without justification. The Committee sustained all Specifications of Misconduct related to Paragraph R and found Respondent's actions to constitute practice of the profession fraudulently, conduct evidencing moral unfitness, advertising not in the public interest, violations of Public Health Law Section 2805-k and the filing of false reports.

FINDINGS RELATED TO FACTUAL ALLEGATION PARAGRAPH S

118. Respondent never applied for membership with the Northeastern Society of Plastic Surgeons (NESPS). In a letter from the NESPS, dated March 29, 2000, Respondent was advised that he was not a member of such association and was directed to cease any representation that he was a member. (Ex. 51, pp.1, 4)

119. Respondent falsely claimed membership in the NESPS in the following manner:

a. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S". (Ex. 25, Ex. 56, Tab 1, p.14)

b. In a document entitled "Pankaj T. Desai, M.D. Curriculum Vitae". (Ex. 56, Tab 14)

c. In an application in 1999 to St. Joseph's Hospital Health Center, and in an attached document entitled "Training and Degrees". (Ex. 56, Tab 13)

d. In an application in 1999 to St. Joseph's Hospital Health Center, and in an attached document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S". (Ex. 56, Tab 1, p.15)

e. In a 1999 application to Oneida Healthcare. (Ex. 58, pp.5, 23, 27)

f. On or around February 9, 2000, and other dates, on his website. (Ex. 56, Tab 18)

g. In a brochure available in his office on May 10 and/or August 3, 2000, entitled "Pankaj T. Desai, M.D. Curriculum Vitae". (Ex. 56, Tab 14; T. 702)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPH S

The Committee **SUSTAINED** all Factual Allegations contained in Paragraph S.

Respondent was never a member of the NESPS, yet he represented that he was in a number of brochures and applications for medical privileges. The Committee found Respondent's representation of being a member of the NESPS to be for the purpose of misleading people into believing he was a member of the Society when, in fact, he knew he was not. The Committee sustained all Specifications of Misconduct related to Paragraph S and found Respondent's actions to constitute practice of the profession fraudulently, conduct evidencing moral unfitness, advertising not in the public interest, violations of Public Health Law Section 2805-k and the filing of false reports.

FINDINGS RELATED TO FACTUAL ALLEGATION PARAGRAPHS T AND U

120. On May 21, 1999, Respondent gave testimony in a malpractice action brought against him by Patient B. (Ex. 11)

121. Respondent falsely failed to identify the pending malpractice action on applications to Oneida Healthcare and St. Joseph's Hospital Health center in 1999. (Ex. 56, Tab 1, p.7, Tab 2; Ex. 58, p.5)

122. Respondent entered into a stipulation in June, 2001 whereby he agreed to the discontinuance of a malpractice action brought against him by Patient S. (Ex. 61)

123. Respondent addressed a letter to the Commissioner of the New York State Department of Health dated October 16, 2001 in which he stated, "Presently, I have not settled or lost a malpractice lawsuit against me". (Ex. 52, p.172)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPHS T AND U

The Committee **SUSTAINED** Factual Allegations T. 3., T. 4 . and the Factual Allegation contained in Paragraph U. All other Allegations were **NOT SUSTAINED.**

The Committee could find no evidence indicating the dates of pending malpractice actions brought against Respondent. It relied on Exhibit 11 as demonstrating that Respondent knew in 1999 of the lawsuit brought by Patient B and therefore considered the 1999 applications for privileges to be inaccurate. By the time of the 2001 letter to the Commissioner, he had resolved the lawsuit brought by Patient S. The Committee considered his actions to reflect an intent to deceive or misrepresent the status of any pending lawsuits and determined the false answers to represent the fraudulent practice of medicine and conduct evidencing moral unfitness.The inaccurate applications were also found be evidence of the filing of false reports.

FINDINGS OF FACT RELATED TO FACTUAL ALLEGATION PARAGRAPH V

124. Respondent participated in a fellowship at Lenox Hill Hospital between January 1982 and June 1982. He resigned from the program before completing it. (Ex. 81)

125. Respondent made the following false statements concerning such fellowship:

a. In applying for licensure as a physician in the State of Ohio in 1985, Respondent claimed that he was in the fellowship between January, 1981 and June, 1982. (Ex. 62, pp. 19, 20, 44, 45)

b. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S.", he stated that he completed the fellowship. (Ex. 56, Tab 1, pp.14-15)

c. On an application for Oneida Healthcare in March, 1999, he listed his participation as being between January, 1981 and June, 1982. (Ex. 58, pp. 23, 27)

d. On an application in March, 1999 to St. Joseph's Hospital Health Center, he submitted a document listing his fellowship as being between July, 1981 and June, 1982. (Ex. 56, Tab 1, pp.11, 13)

e. On an application in March, 1999 to St. Joseph's Hospital Health Center he submitted a document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S.", stating that he had completed the fellowship. (Ex 56, Tab 1, p.15)

f. In a brochure available in his office on May 10, 2000, entitled "Pankaj T. Desai, M.D. Curriculum Vitae", he listed his participation in the fellowship as being between January, 1981 and June, 1982. (T. 702, Ex. 56, Tab 14)

g. In a brochure entitled "Training and Degrees", he listed himself as completing the fellowship. (Ex. 56, Tab 1, p. 13)

h. In the Official American Board of Medial Specialties (ABMS) Directory of Board Certified Medical Specialists for year 1997, Respondent stated that he was at Lenox Hill in a Fifth Pathway program in 1981 and was in an internship from 1981-1982. (Ex. 63)

i. In the Official ABMS Directory of Board Certified Medical Specialists for year 2000, Respondent stated that he was in the fellowship from 1980-1981. (Ex. 64)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPH V

The Committee **SUSTAINED** all Factual Allegations contained in Paragraph V.

It was concluded that the purpose for misrepresenting his credentials would be to induce others to believe he had completed the fellowship, thereby enhancing his reputation. Respondent's actions were found to constitute practice of the profession fraudulently, conduct evidencing moral unfitness, advertising not in the public interest, violations of Public Health Law Section 2805-k and the filing of false reports.

FINDINGS RELATED TO FACTUAL ALLEGATIONS PARAGRAPHS W THROUGH AA

127. On or about September 23, 1999, Respondent was interviewed by the St. Joseph's Hospital Executive Committee to determine whether or not Respondent would retain his privileges at St. Joseph's. During the interview, Respondent made certain statements, in that:

a. Respondent stated that his answer on his application regarding malpractice suits was due to not spending enough time to read the application. (Ex. 56, Tab 6, p.6)

b. Respondent stated to the Executive Committee words to the effect that he was a candidate for membership in the ASPRS and what he needed for membership was to "recertify and retake the membership orientation course and then the

credentialing committee will meet in the year 2000, that's when I'll become a member", when he had not, at that point, submitted an application for membership. (Ex. 56, Tab 6, pp. 9,15, Tab 8)

c. Respondent answered "no" and "never" to questions from a committee member pertaining to whether, after his initial application to St. Elizabeth's and other hospitals in Utica, he had to reapply, recertify or be recredentialed with the hospitals. (Ex. 56)

128. On or about April 13, 2000, Respondent was given a hearing in front of St. Joseph's Executive Committee to appeal the Hospital's decision to revoke his privileges at St. Joseph's. During the hearing, Respondent made certain statements, in that:

a. Respondent stated and implied that he never claimed to be a member of the ASPRS. (Ex. 56, Tab 7, pp. 7-8)

b. Respondent stated that the statement on brochures that he was a member of American Society of Plastic and Reconstructive Surgeons was a mistake by his advertising people. ((Ex. 56, Tab 7, p.6)

c. Respondent stated that the brochures containing questionable information regarding his credentials were no longer available to the visiting public and did not even exist. (Ex. 56, Tab 7, pp. 7,19)

d. Respondent gave contradictory explanations concerning his fellowship; that it was not right to have a brochure state that he had completed the fellowship, and that he was not trying to mislead anybody because he had no idea what they call completion. He further stated that he did not know whether the fellowship was one year or six months, and that there are six month fellowships in other programs. (Ex. 56, Tab 7, pp. 12, 27)

e. Respondent first stated and implied to the Executive Committee that he was once a member of the Northeastern Society of Plastic Surgeons (NESPS), but dropped out, and subsequently stated that he was never a member. (Ex. 56, Tab 7, pp. 31-2)

f. Respondent made statements to lead the Executive Committee to believe that he did not know that the document "How to Choose a Plastic Surgeon" was on his website until he received a letter from the Hospital dated March 8, 2000. (Ex. 56, Tab 7, p. 46)

g. Respondent stated or implied that he directed his web master to modify his website as soon as he was notified that the document "How to Choose a Plastic Surgeon" was there. (Ex. 52, p.85)

h. Respondent stated or implied that his answer concerning medical malpractice actions was because of English not being his primary language, but then said that he was not saying that he did not understand what the word "pending" meant. (Ex. 56, Tab 7, pp. 25-6)

i. Respondent gave, as reasons for his failure to state pending medical malpractice actions, that he thought he only needed to report lawsuits that were settled, lost or won. (Ex. 56, Tab 7, p.24)

j. Respondent stated that he had the largest cosmetic surgery practice in Upstate New York. (Ex. 52, Tab 7, pp. 14-5)

129. Respondent wrote letters to [redacted], Senior Vice President Medical Affairs and Medical Director for Community General Hospital, and [redacted], secretary, both of Community General Hospital, Utica, New York, in which he asserted:

a. In a letter dated June 1, 2000, Respondent wrote concerning the ASPS that he had removed pages from his website and the ASPS "accepted the mistake". (Ex. (Ex. 60, pp. 32-3)

b. In a letter dated September 1, 2000, Respondent was asked why he made the statement that the ASPS had no pending legal action against him and to provide clarification and details. In a letter dated September 12, 2000, Respondent implied and stated that the ASPS had not filed any legal action against him and that he had done nothing wrong concerning the ASPS. (Ex. 60, pp.27-8, 30)

130. Respondent represented or implied that he was "the best in talent" in:

a. an advertisement entitled "Dreams Do Come True," at a time or times known to Respondent before August 15, 2000. (Ex. 52, p. 242)
b. an advertisement entitled "Dreams Do Come True" at a time or times known to Respondent before December 21, 2001. (Ex. 52, p.243)
c. an advertisement entitled "Dreams Do Come True" at a time or times known to Respondent. (Ex. 52, p. 249)

131. Respondent had a full page telephone book advertisement in the telephone books which depicted and implied to be a woman before and after facial surgery. His advertisement in a telephone book from a previous year had used the same person's images but had the words "before" and "after" in quotation marks and the words "computer simulation for illustration":

a. In the Verizon telephone book for Syracuse Metropolitan Area, for use during 2001 until May, 2002. (Ex. 68)
b. In the TransWestern telephone book for Oneida County and Vicinity, for use through December, 2002. (Ex. 67)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PARAGRAPHS W THROUGH AA

These Allegations were each sustained as being factually accurate. The Committee did not determine that they constituted professional misconduct. There was a strong desire to limit the issues to be reviewed to those which prompted Respondent to appear before the Board. Issues related to statements made to other bodies were considered repetitive, cumulative and less significant than those related to Respondent's care and treatment of his patients.

CREDIBILITY

The Committee considered the testimony of the patients who testified to be very credible and accorded significant weight to their statements. They all appeared to be objective and believable with clear recollection of the relevant events and their observations about Respondent's practices were consistent. The Committee recognized the dissatisfaction with his care and treatment, particularly as related to his responses (or lack thereof) to their post-surgical complaints. The patients were viewed to also have been consistent in their attempts to honestly respond to cross-examination inquiries.

Dr. Bonanno and Dr. Moynihan were each considered to be well qualified and their testimony was believed to be honest and objective. It was noted that Dr. Moynihan objectively criticized Respondent's recordkeeping practices. Nurse Brin-Morton's testimony was seen as highly defensive and her memory quite selective. Her claimed ignorance of office practices with which she should have been familiar was not viewed favorably.

The Committee's greatest criticisms were reserved for the Respondent. His testimony was self-serving, evasive, frequently inconsistent and contradictory and his credibility was highly suspect. His statements that he had clear recollection of patients and events that occurred years earlier, in the absence of documentation, were discounted as not worthy of belief. His testimony was rarely considered significant and was given little weight. The Committee believed he routinely engaged in deceptive practices and that he was essentially a dishonest practitioner who preyed on the vulnerabilities of women dissatified with their physical appearances.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee sustained multiple Specifications of Respondent's having practiced with gross negligence, with negligence and incompetence on more than one occasion, practicing fraudulently, having engaged in conduct evidencing moral unfitness, having advertised not in the public interest, having violated Section 2805-k of the Public Health Law and filing false reports. It was determined that his lack of any insight into his deficiencies and the repetitive pattern of misconduct over a period of years was of such an egregious nature that no amount of retraining or monitoring of his practice would adequately protect the public.

Respondent held the position that the many allegations of misconduct were all minor recordkeeping errors unrelated to the management of the patient's care and treatment. Errors which led to the charges of misrepresentation of his credentials and experience were merely unfortunate side effects of conducting a busy practice. These arguments could not be further from the truth. The absence of critical documentation such as operative reports and accurate patient treatments and histories revealed a complete failure to recognize their necessity in overall case management. The use of templates as a substitute for an accurate medical record demonstrated that their purpose was intended merely to protect Respondent from civil liability. He not only admitted the information was inaccurate in his consultation reports; Respondent could not even articulate the purpose for the piece of paper being maintained in the chart.

Cosmetic surgery is still surgery. It is not "more of an art than a science", as asserted by Respondent. Minimally acceptable standards of medicine must be met. While the Committee recognized Respondent has some technical knowledge and skill, his surgical judgement was found to be very poor. He had an exaggerated opinion of his abilities with no insight as to his inadequacies.

The Committee believed Respondent appeared arrogant and that he felt his actions should not be questioned.

Respondent failed to ensure the integrity of the peroneal nerve when he explored Patient A's wound. He performed a wide excision on Patient B before receiving a final pathology report on the diagnosis of a biopsied lesion. He then never informed that patient that the mass was ultimately determined to be benign. Respondent consistently failed to document accurate justification for certain cosmetic surgery procedures, did not document corrective procedures intended to address post-surgical complications and failed to address repeated complaints of post-surgical pain and poor results. He refused to accept that patient complaints were complications, but instead insisted that obvious unsatisfactory results were actually routine occurrences. This pattern of substandard care and treatment of many patients was not merely a technical deficiency.

The Committee also perceived that Respondent engaged in mercenary practices reflecting an overriding objective of financial gain. He advertised extensively in various media and conducted a high volume medical practice which frequently resulted in inadequate patient contact and documentation of relevant information. All patients who testified stated that they learned of Respondent through his advertising; none were referred by other medical personnel. There was evidence in the record that patients authorized cosmetic procedures which were not originally contemplated when Respondent was first consulted, suggesting that they were "sold" other surgeries. Such a practice was testified to by Patient D, who came to Respondent for treatment of varicose veins and ultimately received a chin implant and forehead lift.

The Committee concluded that Respondent was a dishonest practitioner with little or no chance of rehabilitation. His deceptive practices lasted for years and there was no evidence of improvement. Moral responsibilities cannot be taught and Respondent repeatedly demonstrated through numerous fraudulent activities that he is morally unfit to remain in practice. It was clearly apparent to all Committee members that there was no appropriate alternative penalty to that of licensure revocation.

The request by the Department for imposition of a large civil penalty was rejected as unreasonable based on the determination to revoke his license.

ORDER

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

1. The following Specifications of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

   First (in part), Second (in part), Fourth (in part), Fifteenth (in part), Eighteenth through Twenty-fifth (in part), Twenty-nineth through Fifty-seventh, Sixtieth through Seventy-first, Ninety-second through Ninety-nineth (in part), One Hundred Third, One Hundred Fifth through One Hundred Thirty-fourth, One Hundred Thirty-seventh through One Hundred Forty-eighth, One Hundred Seventy-first through One Hundred Ninetieth, Two Hundredth through Two Hundred Sixth, Two Hundred Nineth through Two Hundred Nineteenth and Two Hundred Twenty-second through Two Hundred Twenty-fifth; and

2. All other Specifications of professional misconduct are **NOT SUSTAINED** and are **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

4. 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: Troy, New York

June 23, 2003

William K. Major, Jr. M.D.

WILLIAM K. MAJOR, JR., M.D., CHAIRPERSON

WALTER T. GILSDORF, M.D.
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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF PANKAJ T. DESAI, M.D.	STATEMENT OF CHARGES

PANKAJ T. DESAI, M.D., Respondent, was authorized to practice medicine in New York State on May 15, 1987, by the issuance of license number 170132 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 5 year old male, (patients are identified in Appendix A, attached, for confidentiality reasons) from on or about July 24, 1998, until approximately August 3, 1998, at St. Luke's Hospital Emergency Department, Utica, New York, and at Respondent's office. Respondent's care of Patient A did not meet acceptable standards of care in that:

1. On or around July 24, 1998, Respondent failed to obtain and/or document an adequate pre-operative history for Patient A, who he reported to have multiple severe soft tissue injuries to the leg.
2. Respondent failed to perform and/or document an adequate physical examination of Patient A, including the wounds, and/or fraudulently recorded a neurological assessment of the patient's leg and foot.
3. Respondent used inappropriate anesthesia for the surgery and/or failed to seek anesthesia consult.
4. Respondent failed to take adequate steps to prepare the operative field.
5. Respondent failed to adequately assess and/or explore the patient's wound or wounds.
6. Respondent either failed to recognize that Patient A's peroneal nerve had been damaged or lacerated, or he damaged or lacerated the peroneal nerve.
7. Respondent failed to prepare an adequate operative note.

8. Respondent failed to adequately evaluate Patient A during the July 30, 1998, post-operative visit.

9. Respondent failed to seek appropriate surgical consult for the July 24, 1998, surgery and/or adequately document why, on August 3, 1998, he referred the patient to another physician for treatment.

B. Respondent provided care for Patient B, a female born August 17, 1957, from on or about May 12, 1993, to around December 1996, at St. Elizabeth's Hospital and Respondent's office. Respondent's care of Patient B failed to meet accepted standards of care, in that:

1. Respondent's notes from May and June 1993 are inadequate and/or inconsistent concerning the size and/or location of a possible lesion.

2. On or about May 26, 1993, Respondent inappropriately or fraudulently reported to Patient B and/or her husband that the pathology report from the May 19, 1993, excision from her buttocks revealed a malignancy and/or told her and/or her husband that she had liposarcoma.

3. On or about May 26, 1993, Respondent recommended wide excision of a tumor from Patient B's buttocks without adequate indication.

4. In the hospital record for the procedure on or about June 2, 1993, Respondent fraudulently or inappropriately reported a final diagnosis of malignant lesion without adequate basis.

5. Respondent fraudulently or inappropriately never told Patient B that the tissue removed from her on or around May 19, 1993, was not malignant.

6. Respondent fraudulently or inappropriately told Patient B that she had a 90% chance that cancer could recur.

7. Respondent fraudulently or inappropriately told Patient B that she needed to return for followup visits to check for cancer.

8. Respondent's pre-operative note dated September 11, 1996 and/or his operative note dated September 25, 1996, contain fraudulent and/or inaccurate statements, including but not limited to: the patient wears foundation during makeup, the patient was fully told of risks of severe and/or permanent scarring, possibility of future revision surgery, infection, full thickness burns and/or facial disfigurement.

9. Respondent failed to appropriately calibrate a laser before using it on Patient B's face on or around September 25, 1996.

10. For the operative report dated September 25, 1996, Respondent fraudulently used a letter head with the symbol and name of the American Society of Plastic and Reconstructive Surgeons, Inc., when he was not a member of that society.

11. Respondent fraudulently or inappropriately failed to accurately record an assessment of the patient's condition and/or the complaints of the patient and/or her husband concerning the results of the laser procedure.

12. Respondent failed to adequately respond to and/or refer Patient B for complications from the laser procedure.

13. Respondent failed to adequately follow up on a culture obtained from Patient B.

14. On May 21, 1999, in testimony under oath in a suit against him by Patient B, Respondent fraudulently testified that he told the patient before the laser treatment that "The percentage of scarring is about four to sixteen percent depending upon who is doing the surgery." when he had not done so.

C. Respondent provided care for Patient C, a female born February 27, 1960, on or about October 1, 1998, to around March 1999, at Respondent's office.

Respondent's care of Patient C failed to meet accepted standards of medical care, in that:

1. In consultations dated October 1, 1998, Respondent fraudulently or inaccurately made false statements including but not limited to: his notation of the length and duration of the problem or problems, patient reports of mental embarrassment, his notation in the chart of the patient's treatment to date, demonstration of computer graphic imaging, that full graphic presentation of rhinoplasty was carried out in diagrams, the patient viewing video, the length of time the patient was considering liposuction, the drawing of a diagram or diagrams, the giving of surgical options, the taking of vital signs, the noting of current medications, the obtaining of history of smoking, diabetes, collagen vascular disease, the completion of patient evaluation form, obtaining information about prior and planned pregnancies and/or attitudes towards nursing.

2. Respondent fraudulently prepared and signed a history and physical examination dated December 30, 1998, for St. Elizabeth Hospital when he had not performed or been present for a history or physical.

3. Respondent failed to perform an adequate pre-operative assessment before surgery on January 6, 1999.

4. On January 6, 1999, Respondent performed what he reported as a reconstructive rhinoplasty without having or documenting adequate indication.

5. On January 6, 1999, Respondent performed what he reported to be the Lejoure technique of reduction mammoplasty without adequate training.

6. Respondent failed to properly perform reduction mammoplasty for Patient C, resulting in an inappropriate scar and/or inappropriate placement of the nipple/areolar complexes.

7. Through the course of post-operative treatment after the various procedures, Respondent inappropriately and/or fraudulently failed to assure that the record accurately stated the patient's complaints and/or condition.

8. On February 24, 1999, Respondent performed revision surgery on Patient C: without performing or documenting an adequate pre-operative consultation; without an adequate pre-operative assessment; too soon following January 6 surgery; without obtaining or documenting adequate authorization; without preparing an adequate operative report; and/or without attempting revision of the "dog ear" flap despite the patient's request and /or authorization that he do so.

9. Respondent proposed to Patient C that he perform surgery on her in March 1999, without documenting his findings, assessment, and/or plan.

D. Respondent provided care for Patient D, a female born April 4, 1949, from on or about May 2000 to approximately February 2001, at Respondent's office.

Respondent's care of Patient D failed to meet accepted standards of care, in that:

1. In consultations dated June 7, 2000, Respondent fraudulently or inaccurately made false statements including but not limited to: his notation of treatment to date, taking of vital signs, charting of the location, size and description of the disorder or disorders in anatomical form, showing of video to the patient, administration of the Brodie-Trendelenberg test and entry of it in the chart, the use of the percussion/Schwartz test with a tourniquet, use of the Perthes test, the obtaining of Doppler characteristics, the carrying out of an eye screen examination, obtaining history regarding mood altering medications, explanation of the risks of surgery, and/or performance of computer graphic imaging.

2. On or around July 5, 2000, Respondent administered injections into the patient's legs to treat concerns of varicose veins without adequate documentation of the procedures.

3. On July 31, 2000, Respondent failed to properly examine the patient's mouth, to state an accurate condition of the patient's oral hygiene, and/or inappropriately performed a chin implant procedure on Patient D utilizing an intra-oral route after observing that dental hygiene was "not so well."

4. On September 29, 2000, Respondent: removed the chin implant and/or replaced it without performing or documenting an adequate pre-operative evaluation/consultation; failed to adequately describe the procedure, the replacement implant, the anesthesia and/or the anesthesiologist in the operative report; failed to take adequate cultures of what he diagnosed to be an infected chin implant and/or inappropriately placed a second chin implant after removing what he diagnosed to be an infected chin implant.

5. On October 9, 2000, Respondent: removed the second implant without performing or documenting an adequate pre-operative evaluation/ consultation; without preparing an adequate operative report; and/or without taking an appropriate culture.

6. On December 26, 2000, Respondent performed fat injections and revision of the endoscopic brow-lid without performing or documenting an adequate evaluation and/or without preparing an adequate operative report.

7. Through the course of post-operative treatment after the various procedures, Respondent inappropriately and/or fraudulently failed to assure that the record accurately stated the patient's complaints and/or condition in her post-operative follow up visits.

8. Respondent fraudulently or inappropriately prepared an undated procedure note for glycolic acid peel for Patient D when no such treatment occurred.

9. Respondent fraudulently or inappropriately made a chart entry dated 2/1/01 concerning statements made by the patient concerning marital matters and/or her emotional status when such were not true.

E. Respondent provided care for Patient E, a female born November 26, 1956, from on or about March 19, 1998 to around February 1999, at Respondent's office. 11/4/02 ja

Respondent's care of Patient E failed to meet accepted standards of care, in that:

1. In consultations dated March 19, 1998, Respondent fraudulently or inaccurately made false statements including but not limited to: the patient having low self esteem secondary to hypoplastic breasts, her desiring breast surgery for a long period of time, her wearing wonder bras and padded bras, her being not happy, examination of the patient's breasts, completion of a form showing location of nipple areolar complexes in relation to the suprasternal notch, discussion of location of implants, her consideration of liposuction for several years, notation of length and duration of the problem, discussion of risks, performance of computer graphic imaging, the viewing of a videos, informing the patient that she may need to undergo a weight management program, and/or discussion of generalized obesity.

2. Respondent had available for the patient a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.A.C.S., F.I.C.S." which fraudulently represents that he completed a fellowship at Lenox Hill Hospital, was a member of the American Society of Plastic and Reconstructive Surgeons, and/or the North Eastern Society of Plastic Surgeons.

3. On or around May 4, 1998, Respondent fraudulently had available in his office and/or used an operative scheduling letter which fraudulently represents or implies that he was a member of the American Society of Plastic and Reconstructive Surgeons, Inc., when he was not a member.

4. Respondent did not appropriately document why he placed the breast implants in the submuscular position when he wrote in the consultation that the proposed surgery was for placement in the submammary position.

5. During a May 8, 1998, procedure, Respondent inappropriately performed a full abdominoplasty and the reported liposuction. 11/4/02 ja

6. On or around November 23, 1998, Respondent inappropriately treated Patient E's hematoma by liposuction.

7. Respondent failed to prepare an adequate operative report for surgery performed on November 23, 1998, including revision of umbilicus, open or closed capsulotomy, and/or revision of dog ear right abdominal incision.

8. Respondent inappropriately stated, without adequate basis, that the patient's post-operative complication was a result of fat necrosis.

9. Respondent wrote fraudulent or inaccurate record entries to the effect that Patient E was "quite happy and satisfied" with the results of the May 8, 1998 surgery.

10. Respondent's fraudulently or inappropriately failed to record that he proposed surgery for the patient in January 1999 and/or his findings, assessment and/or plan.

F. Respondent provided care for Patient F, a female born April 17, 1950, from on or about December 27, 2000, to around March 2001, at Respondent's office.

Respondent's care of Patient F failed to meet accepted standards of care, in that:

1. In consultations dated December 27, 2000, Respondent fraudulently or inaccurately made false statements including but not limited to: that treatment to date has been outlined in graphic form, that an eye screen examination was carried out, that the length and duration of the problem has been gradual and noted, that a video was shown, that the overall different wrinkles were outlined in the patient's chart, and/or stating the patient had been considering liposuction for several years.

2. Respondent failed to perform and/or document adequate pre-operative evaluation of Patient F, who had only one kidney.

3. Respondent fraudulently or inappropriately told Patient F that he was "the best" and/or that she would be beautiful after surgery.

4. Respondent failed to inform or document informing Patient F of the necessity of stopping smoking weeks before the abdominoplasty he performed on January 5, 2001, and/or assure that she had stopped smoking.

5. Respondent's operative note of January 5, 2001, is fraudulent or inaccurate in that he prepared two operative reports for the same date listing different anesthesiologists, mentions discussions with the patient concerning smoking that did not occur and/or states that no drains were inserted when there were.

6. On or around January 24, 2001, Respondent inappropriately or fraudulently stated or implied that Patient F's symptoms were due to a urinary tract infection and/or prescribed Bactrim DS without adequate indication or evaluation.

7. Concerning surgery on January 30, 2001, Respondent: failed to perform or record an adequate pre-operative evaluation of Patient F; failed to complete an adequate operative report for the revisional surgery of Patient

F's right lower eyelid on January 30, 2001, and/or attempted an inappropriate procedure for the patient's problem.

8. Respondent's handwritten notes are not adequately legible.

9. Respondent fraudulently or inappropriately failed to perform or record an adequate assessment of the patient's condition post-operatively and/or the complaints and concerns of Patient F after the January 5 and /or January 30, 2001 surgeries.

10. Respondent fraudulently or inappropriately failed to record that he proposed to perform a third surgery around the patient's eyes and/or his findings, assessment and/or plan.

G. Respondent provided care for Patient G, a female born November 1, 1973, from on or about October to November 2001, at Respondent's office. Respondent's care of Patient G failed to meet accepted standards of care, in that:

1. In a consultation dated October 24, 2001, Respondent fraudulently or inaccurately made false statements including but not limited to: that areas of unwanted hair were noted on the graph, the patient complained that her problem had been since puberty, that the unwanted hair growth areas were noted in the chart, and/or that complications of scarring were explained.

2. Respondent failed to obtain adequate informed consent for laser treatment to be performed by other than medical staff.

3. Respondent failed to note the results of a test patch to test for depigmentation.

4. Respondent failed to adequately control the laser pre- and/or intra-operatively and/or to report an adverse event concerning use of the laser.

5. Respondent fraudulently or inaccurately created an operative report dated October 29, 2001, listing himself as the surgeon when he was not present and/or did not operate the laser.

6. During follow up after the laser treatment, Respondent fraudulently or inappropriately: failed to perform or document an adequate evaluation or treatment of the condition of the patient's face and/or told the patient that her face was not burned.

H. Respondent provided care for Patient H, a 25 year old female, from around July 2000 to around September 2000, at Respondent's office. Respondent's care of Patient H failed to meet accepted standards of care, in that:

1. In a consultation note dated July 12, 2000, Respondent fraudulently or inaccurately made false statements including but not limited to: stating or implying that he was present for the consultation, that areas of unwanted hair were noted on the graft (sic), the patient complained that her problem

had been since puberty, that the unwanted hair growth areas were noted in the chart and/or that complications of scarring were explained.

11/18/02 2. Respondent failed to adequately control the laser pre- and/or intra-operatively on August 4, 2000 and/or September 15, 2000, or failed to report an adverse event concerning use of the laser and/or the post-treatment complications.

3. Respondent fraudulently or inaccurately created an operative report dated August 4, 2000, listing himself as the surgeon when he was not present and/or did not operate the laser.

4. Respondent failed to obtain adequate authorization from the patient for the laser procedure to be performed by non-medical personnel.

5. Respondent inappropriately or fraudulently failed to adequately evaluate or record the patient's complaints and/or condition post-operatively.

I. Respondent provided care for Patient I, a female born September 27, 1979, from around October 1999 to around January 2000, at Respondent's office.

Respondent's care of Patient I failed to meet accepted standards of care, in that:

1. In a consultation dated October 11, 1999, Respondent fraudulently or inaccurately made false statements including but not limited to: that breast measurements were taken the day of the consult, the patient has been wearing wonder bras and padded bras to alleviate the problem of hypoplasia, the taking of vital signs, that she had been desirous to undergo surgery for a long period of time, discussion of different incisions, and/or the planned location of implants.

2. Respondent told Patient I words to the effect that nothing would go wrong with the surgery, that she would be very satisfied, and/or that she would love the result.

3. Concerning the operation of October 21, 1999, Respondent fraudulently or inaccurately: created two operative reports for an augmentation mammoplasty, one describing a submammary placement, the other describing a submuscular placement; wrote a diagnosis of fibrocystic disease for Patient I without adequate indication and/or documentation; listed an anesthesiologist that was not involved in the procedure; did not appropriately document why he placed the breast implants in the submuscular position when he wrote in the consultation that the proposed surgery was for placement in submammary position; and/or stated that computer graphic imaging had been carried out when it had not.

4. In the augmentation mammoplasty, Respondent inappropriately placed the implants and/or used inappropriate sized implants.

5. Respondent fraudulently or inappropriately failed to perform or record an adequate assessment of the patient's condition post-operatively and/or the complaints and concerns of Patient I.

6. Respondent inappropriately asked Patient I if she would give him a free dance if he came to the club where she was a dancer.

7. Respondent does not have an adequate understanding of methods for remedying the errors.

8. Respondent proposed to Patient I that he perform additional breast surgery on her in April and fraudulently or inappropriately failed to document his findings, assessment, and/or plan.

9. On June 13, 2001, in testimony under oath in a claim by Patient I, Respondent fraudulently testified that "...when I was examining her she stated that she's a dancer, and she wants to have the implants under the muscle."

10. On June 13, 2001, in testimony under oath in a claim brought against him by Patient I, Respondent fraudulently testified that he told the patient that "...implanting in subglandular position is a better way to go, but we can make an attempt to put implants under the muscle provided she understands that she may need some revision surgery later on."

11. On June 13, 2001, in testimony under oath in a claim brought against him by Patient I, Respondent fraudulently testified that he told the patient "I need to warn you that chances are very high that you will need revision surgery."

J. Respondent provided care for Patient J, a female born May 23, 1970, from around March 15, 2000 to around August 2000, at Respondent's office. Respondent's care of Patient J failed to meet accepted standards of care, in that:

1. In his operative report dated March 28, 2000, Respondent fraudulently or inaccurately wrote a diagnosis of fibrocystic disease for Patient J.

2. In his operative report dated March 28, 2000, Respondent did not appropriately document why he placed the breast implants in the submuscular position when he wrote in the consultation that the proposed surgery was for placement in submammary position.

K. Respondent provided care for Patient K, a female born June 18, 1980, beginning around December 1998 to around January 2000. Respondent's care of Patient K was not in accordance with acceptable standards of care, in that:

1. Respondent either performed no adequate pre-operative history and/or physical or failed to document it.

2. In his operative report dated December 29, 1998, Respondent fraudulently or inaccurately wrote a diagnosis of fibrocystic disease for Patient K.

3. In his operative report dated December 29, 1998, Respondent did not appropriately document why he placed the breast implants in the submuscular position when he wrote in the consultation that the proposed surgery was for placement in submammary position.

L. Respondent provided care for Patient L, a female born March 26, 1975, from around June 2000 to around April 2001, at Respondent's office. Patient L was later employed by Respondent from around November 2000 to around April 2001. Respondent's conduct toward Patient L failed to meet accepted standards of care, in that:

1. In a consultation dated June 28, 2000, Respondent fraudulently or inaccurately made false statements including but not limited to: the areas of the body for liposuction have been outlined in the chart, the diagram has been properly drawn, the length and duration of the problem were noted in the graphic chart, the patient had been thinking about liposuction for several years, a video was shown to the patient, she was given patient education brochures, different types of liposuction were discussed, blood loss was discussed, that diet and exercises were discussed and/or that the patient may need to go through a weight management program. w|D

2. Respondent's operative notes do not adequately describe the procedures he performed on the patient on July 21, 2000, and/or on October 24, 2000. w|D

3. In April 2001, Respondent obtained consent for and/or performed scar revision surgery without adequate performance or documentation of an adequate evaluation of the Patient.

4. On or around April 5, 2001, Respondent performed surgery on Patient L without preparing an adequate operative note.

5. From on or about November 2000 to approximately April 2001, on multiple occasions, Respondent inappropriately approached Patient L in a sexual manner, including asking whether she was good in bed and that he could teach her many things, asking whether she would participate in a threesome, asked whether they could have sex using a jolly jumper after she showed him a picture of her baby brother in one, asking whether he could come and sleep in her bed, asking whether she would engage in a gang bang, told her she needed to get her tongue pierced and "show him what she could do with it," meaning oral sex, after he performed surgery on her in April, grabbed her breast and/or said to her that he loved them and/or after she had given notice, asking if they could have sex since she would no longer be an employee. w|D

JA 12/30/02

M. Respondent employed Nurse M from around December 2000 until around April 2001. Respondent's conduct with Nurse M did not meet acceptable standards in that:

1. Respondent asked Nurse M to engage in sexual acts with him, with him and other employees, and/or asked patients to engage in sexual acts with him in her presence.

2. Respondent fraudulently or inappropriately told Nurse M to not record all patient complaints and/or all of her observations of patient condition.

N. Respondent employed Employee N, a licensed massage therapist, between around May 1999 and December 1999. Respondent's conduct toward Employee N did not meet acceptable standards in that he made sexual comments and suggestions to her, including asking her to go to his house to give him a massage when Respondent's wife was out of town, asking her to spend the entire night with him, asking if she would give him a massage in the dark, stating that he would "impress her with his size" or words to that effect, asked her to engage in "hanky panky," and/or kissed her without her consent.

12/30/02 withdrawn

O. On February 9, 2000, and/or on other dates as well, Respondent fraudulently or inappropriately published on his website a document "How to Choose a Qualified Plastic Surgeon," which was an unauthorized use of copyrighted materials of the American Society of Plastic Surgery (ASPS), formerly the American Society of Plastic and Reconstructive Surgeons (ASPRS).

P. Respondent infringed the trademark of the American Society of Plastic Surgeons , by producing, distributing and placing into the market both printed and Internet based marketing and/or advertising materials with the intent to solicit patients for Respondent's medical practice and such infringement was likely to cause confusion, to cause mistake or to deceive, and infringe on ASPS's rights in their trademark.

Q. Respondent infringed on the ASPS copyrighted work, "How to Choose a Qualified Plastic Surgeon," by producing, distributing and placing into the market both printed and Internet based marketing and/or advertising materials with the intent to solicit patients for Respondent's medical practice.

R. Respondent fraudulently or inaccurately represented himself to be a member of the American Society of Plastic and Reconstructive Surgeons, or ASPRS, now the American Society of Plastic Surgeons, or ASPS, as follows:

1. In a 1988 application to the Medical Liability Mutual Insurance Company.
2. In a 1988 application to Little Falls Hospital.
3. In a 1990 application to St. Elizabeth, Faxton and St. Luke's Hospitals.
4. In the Directory of the Medical Society of the State of New York for 1993-1994.
5. In a 1994 application to Little Falls Hospital.
6. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S."
7. In a document entitled "Pankaj T. Desai, M.D. Curriculum Vitae"
8. In a document dated June 25, 1996, concerning Patient O.
9. In a document dated July 31, 1996, concerning Patient O.
10. In a document dated January 24, 1997, concerning Patient P.
11. In a document dated May 19, 1997, and/or in another undated document concerning Patient Q.
12. In the Directory of the Medical Society of the State of New York for 1997-1998.
13. In an application in 1999, to St. Joseph's Hospital Health Center, and/or in an attached document entitled "Training and Degrees."
14. In an application in 1999, to St. Joseph's Hospital Health Center, and/ or in an attached document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S."
15. In a document dated around June 1999, concerning Patient R.
16. In a 1999 application to Oneida Healthcare.
17. On or around February 7 and/or 9, 2000, and other dates, on his website, www.dr-desai.com.
18. On or around March 8, 2000, and other dates, on his website, www.dr-desai.com.
19. In a brochure available in his office on May 10, 2000, and/or entitled "Pankaj T. Desai, M.D. Curriculum Vitae."
20. In the Directory of the Medical Society of the State of New York for 1999-2000.

S. Respondent fraudulently or inaccurately represented himself to be a member of the North Eastern Society of Plastic Surgeons (properly titled the Northeastern Society of Plastic Surgeons) (NESPS), as follows:

1. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S."
2. In a document entitled "Pankaj T. Desai, M.D. Curriculum Vitae."
3. In an application in 1999 to St. Joseph's Hospital Health Center, and/or in an attached document entitled "Training and Degrees."
4. In an application in 1999 to St. Joseph's Hospital Health Center, and/or in an attached document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S."
5. In a 1999 application to Oneida Healthcare.
6. On or around February 9, 2000, and other dates, on his website.
7. In a brochure available in his office on May 10, 2000, entitled "Pankaj T. Desai, M.D. Curriculum Vitae."

T. Respondent fraudulently or inaccurately failed to identify pending malpractice actions as follows:

1. On an application to Faxton Hospital, St. Elizabeth Hospital, and St. Luke's Memorial Hospital in 1996.
2. On an application to Faxton Hospital, St. Elizabeth Hospital, and St. Luke's Memorial Hospital in 1998.
3. On an application to Oneida Healthcare in 1999.
4. On an application to St. Joseph's Hospital Health Center in 1999.

U. In a letter dated October 16, 2001, addressed to the Commissioner of the New York State Department of Health, Respondent fraudulently stated "Presently, I have not settled or lost a malpractice lawsuit against me." when at least one malpractice lawsuit against him, with Patient S, had been settled.

V. Respondent fraudulently or inaccurately described his participation in a fellowship at Lenox Hill Hospital between around January 1982 and June 1982 as follows:

1. In applying for licensure as a physician in the State of Ohio in 1985, Respondent claimed that he was in the fellowship between January 1981 and June 1982.

2. In a brochure entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S." he stated that he completed the fellowship.

3. On an application for Oneida Healthcare in March 1999 he listed his participation as being between January 1981 and June 1982.

4. On an application in March 1999 to St. Joseph's Hospital Health Center he submitted a document listing his fellowship as being between July 1981 and June 1982.

5. On an application in March 1999 to St. Joseph's Hospital Health Center he submitted a document entitled "Aesthetic Laser Surgery Center Pankaj T. Desai, M.D., M.S., F.I.C.S." stating that he had completed the fellowship.

6. In a brochure available in his office on May 10, 2000, entitled "Pankaj T. Desai, M.D. Curriculum Vitae" he listed his participation in the fellowship as being between January 1981 and June 1982.

7. In a brochure entitled "Training and Degrees" he listed himself as completing the fellowship.

8. In the Official American Board of Medial Specialties (ABMS) Directory of Board Certified Medical Specialists for year 1997, Respondent stated that he was at Lenox Hill in a Fifth Pathway program in 1981 and /or was in an internship from 1981 to 1982.

9. In the Official ABMS Directory of Board Certified Medical Specialists for year 2000, Respondent stated that he was in the fellowship from 1980 to 1981.

W. On or about September 23, 1999, Respondent was interviewed by the St. Joseph's Hospital Executive Committee to determine whether or not Respondent would retain his privileges at St. Joseph's. During the interview, Respondent made fraudulent and/or inaccurate statements, in that:

1. Respondent stated that his false answer on his application regarding malpractice suits was due to not spending enough time to read the application.

2. Respondent stated to the Executive Committee words to the effect that he was a candidate for membership in the ASPRS and/or what he needed for membership was to "recertify and retake the membership orientation course and then the credentialing committee will meet in the year 2000, that's when I'll become a member" when he had not, at that point, even submitted an application for membership.

3. Respondent answered "no" and "never" to questions from a committee member pertaining to whether, after his initial application to St. Elizabeth's

and other hospitals in Utica, he had to reapply or be recredentialed, or had to recertify or reapply with the hospitals.

X. On or about April 13, 2000, Respondent was given a hearing in front of St. Joseph's Executive Committee to appeal the Hospital's decision to revoke his privileges at St. Joseph's. During the hearing, Respondent made fraudulent statements, in that:

1. Respondent stated or implied that he never claimed to be a member of the ASPRS when Respondent knew or had reason to know that he had claimed to be an ASPRS member.

2. Respondent stated that the statement on brochures that he was a member of American Society of Plastic and Reconstructive Surgeons was a mistake by his advertising people.

3. Respondent stated that the brochures containing questionable information regarding his credentials were no longer available to the visiting public and/or did not even exist.

4. Respondent gave contradictory explanations concerning his fellowship: he said that it was not right to have a brochure state that he had completed the fellowship, but then stated that he was not trying to mislead anybody because he had no idea what they call completion, stated he did not know whether the fellowship was one year or six months, and/or that there are six month fellowships in other places.

5. Respondent first stated or implied to the Executive Committee that he was once a member of the Northeastern Society of Plastic Surgeons (NESPS) but dropped out, but then stated that he was never a member.

6. Respondent made statements to lead the Executive Committee to believe that he did not know that the document "How to Choose a Plastic Surgeon" was on his website until he received a letter from the Hospital dated March 8, 2000, when he had been sent a letter dated February 9, 2000, from the legal counsel for the ASPRS demanding that he remove that document from his website because: it was copyrighted material; it implied he was a member when he was not; and he was not authorized to use it.

7. Respondent stated or implied that he directed his web master to modify his website as soon as he was notified that the document "How to Choose a Plastic Surgeon" was there, when he did not comply with a letter from the legal counsel for the ASPRS dated February 9, 2000, demanding that he remove that document from his website because it was copyrighted material and he was not authorized to use it.

8. Respondent stated or implied that his false answer concerning medical malpractice actions was because of English not being his primary language, but then said that he was not saying that he did not understand what the word "pending" meant.

9. Respondent gave, as reasons for his failure to honestly state pending medical malpractice actions, that he thought he only needed to report lawsuits that were settled, he lost, or won.

10. Respondent stated that he had the largest cosmetic surgery practice in Upstate New York without adequate basis for such a statement.

Y. Respondent wrote letters to [redacted], Senior Vice President Medical Affairs and Medical Director for Community General Hospital, and/or [redacted], secretary, both of Community General Hospital, Utica, New York. Respondent made fraudulent and/or inaccurate statements, in that:

1. In a letter dated June 1, 2000, Respondent wrote concerning the ASPS that he has removed pages from his website and the ASPS "accepted the mistake," when Respondent knew or had reason to know that he had no basis for that assertion because the ASPS had sent him a cease and desist letter dated February 9, 2000, after which the ASPS filed suit in Federal Court, and continued that court case until they obtained a court order directing Respondent to stop using their copyrighted and/or trademarked materials.

2. In a letter dated September 1, 2000, Respondent was asked why he made the statement that the ASPS had no pending legal action against him and to provide clarification and details. In a letter dated September 12, 2000, Respondent fraudulently implied or stated that the ASPS had not filed any legal action against him and/or that he had done nothing wrong concerning the ASPS when legal action had been filed against him by the ASPS for copyright and/or trademark infringement, among other things, and that by order dated May 3, 2000, he had been ordered, in essence, to not hold himself out as an ASPS member or infringe its trademarked and/or copyrighted materials.

Z. Respondent fraudulently or inaccurately represented or implied that he was "the best in talent" in:

1. an advertisement entitled "Dreams Do Come True," at a time or times know to Respondent before August 15, 2000.

2. an advertisement entitled "Dreams Do Come True" at a time or times known to Respondent before December 21, 2001.

3. an advertisement entitled "Dreams Do Come True" at a time or times known to Respondent.

AA. Respondent had a full page telephone book advertisement in the telephone books listed below which fraudulently and/or inaccurately depicted or implied to be a

woman before and after facial surgery when the "after" picture was not the result of his surgery; whereas his ad in a previous telephone book used the same person's images but had the words "before" and "after" in quotation marks and the words "computer simulation for illustration":

1. In the Verizon telephone book for Syracuse Metropolitan Area, for use during 2001 until May 2002.

2. In the TransWestern telephone book for Oneida County and Vicinity, for use through December 2002.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.11, B and B.12, B and B.13, C and C.1, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, J and J.1, J and J.2, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, M and M.1, M and M.2, and/or N.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B

and B.9, B and B.11, B and B.12, B and B.13, C and C.1, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, J and J.1, J and J.2, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, M and M.1, M and M.2, and/or N.

THIRD THROUGH SIXTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

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

3. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8 and/or A and A.9.

4. The facts of paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.11, B and B.12, and/or B and B.13.

5. The facts of paragraphs C and C.1, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8 and/or C and C.9.

6. The facts of paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8 and/or D and D.9.

7. The facts of paragraphs E and E.1, E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9 and/or E and E.10.

8. The facts of paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9 and/or F and F.10.

9. The facts of paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5 and/or G and G.6.

10. The facts of paragraphs H and H.1, H and H.2, H and H.3, H and H.4 and/or H and H.5.

11. The facts of paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7and/or I and I.8.

12. The facts of paragraphs J and J.1 and/or J and J.2.

13. The facts of paragraphs K and K.1, K and K.2, K and/or K.3.

14. The facts of paragraphs L and L.1, L and L.2, L and L.3, L and L.4 and L and L.5.

15. The facts of paragraphs M and M.1 and/or M and M.2.

16. The facts of paragraphs N.

SEVENTEENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as set forth in any combination of one or more of the following:

17. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.11, B and B.12, B and B.13, C and C.1, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, J and J.1, J and J.2, K and K.1, K and K.2, K and K.3, L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, M and M.1, M and M.2, and/or N.

EIGHTEENTH THROUGH NINETY FIRST SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently as defined in N.Y. Educ. Law § 6530(2) as set forth in the following:

18. The facts of paragraphs B and B.2, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.10, B and B.11, and/or B and B.14.

19. The facts of paragraphs C and C.1, C and C.2 and/or C and C.7.

20. The facts of paragraphs D and D.1, D and D.7, D and D.8 and/or D and D.9.

21. The facts of paragraphs E and E.1, E and E.2, E and E.3, E and E.9 and/or E and E.10.

22. The facts of paragraphs F and F.1, F and F.3, F and F.5, F and F.6, F and F.9 and/ or F and F.10.

23. The facts of paragraphs G and G.1, G and G.5 and/or G and G.6.

24. The facts of paragraphs H and H.1, H and H.3, and/or H and H.5.

25. The facts of paragraphs I and I.1, I and I.3, I and I.5, I and I.8, I and I.9, I and I.10 and/or I and I.11.

26. The facts of paragraphs J and J.1.

27. The facts of paragraphs K and K.2.

28. The facts of paragraphs L and L.1.

29. The facts of paragraph O.

30. The facts of paragraph P.

31. The facts of paragraphs R and R.1.

32. The facts of paragraphs R and R.2.

33. The facts of paragraphs R and R.3.

34. The facts of paragraphs R and R.4.

35. The facts of paragraphs R and R.5.

36. The facts of paragraphs R and R.6.

37. The facts of paragraphs R and R.7.

38. The facts of paragraphs R and R.8.

39. The facts of paragraphs R and R.9.

40. The facts of paragraphs R and R.10.

41. The facts of paragraphs R and R.11.

42. The facts of paragraphs R and R.12.

43. The facts of paragraphs R and R.13.

44. The facts of paragraphs R and R.14.

45. The facts of paragraphs R and R.15.

46. The facts of paragraphs R and R.16.

47. The facts of paragraphs R and R.17.

48. The facts of paragraphs R and R.18.

49. The facts of paragraphs R and R.19.

50. The facts of paragraphs R and R.20.

51. The facts of paragraphs S and S.1.

52. The facts of paragraphs S and S.2.

53. The facts of paragraphs S and S.3.

54. The facts of paragraphs S and S.4.

55. The facts of paragraphs S and S.5.

56. The facts of paragraphs S and S.6.

57. The facts of paragraphs S and S.7.

58. The facts of paragraphs T and T.1.

59. The facts of paragraphs T and T.2.

60. The facts of paragraphs T and T.3.

61. The facts of paragraphs T and T.4.

62. The facts of paragraph U.

63. The facts of paragraphs V and V.1.

64. The facts of paragraphs V and V.2.

65. The facts of paragraphs V and V.3.

66. The facts of paragraphs V and V.4.

67. The facts of paragraphs V and V.5.

68. The facts of paragraphs V and V.6.

69. The facts of paragraphs V and V.7.

70. The facts of paragraphs V and V.8.

71. The facts of paragraphs V and V.9.

72. The facts of paragraphs W and W.1.

73. The facts of paragraphs W and W.2.

74. The facts of paragraphs W and W.3.

75. The facts of paragraphs X and X.1.

76. The facts of paragraphs X and X.2.

77. The facts of paragraphs X and X.3.

78. The facts of paragraphs X and X.4.

79. The facts of paragraphs X and X.5.

80. The facts of paragraphs X and X.6.

81. The facts of paragraphs X and X.7.

82. The facts of paragraphs X and X.8.

83. The facts of paragraphs X and X.9.

84. The facts of paragraphs X and X.10.

85. The facts of paragraphs Y and Y.1.

86. The facts of paragraphs Y and Y.2.

87. The facts of paragraphs Z and Z.1.

88. The facts of paragraphs Z and Z.2.

89. The facts of paragraphs Z and Z.3.

90. The facts of paragraphs AA and AA.1.

91. The facts of paragraphs AA and AA.2.

NINETY-SECOND THROUGH

ONE HUNDRED SIXTY EIGHTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as set forth in the following:

92. The facts of paragraphs B and B.2, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.10, B and B.11 and/or B and B.14.

93. The facts of paragraphs C and C.1, C and C.2 and/or C and C.7.

94. The facts of paragraphs D and D.1, D and D.7, D and D.8 and/or D and D.9.

95. The facts of paragraphs E and E.1, E and E.2, E and E.3, E and E.9 and/or E and E.10.

96. The facts of paragraphs F and F.1, F and F.3, F and F.5, F and F.6, F and F.9 and/ or F and F.10.

97. The facts of paragraphs G and G.1, G and G.5 and/or G and G.6.

98. The facts of paragraphs H and H.1, H and H.3 and/or H and H.5.

99. The facts of paragraphs I and I.1, I and I.3, I and I.5, I and I.6, I and I.8, I and I.9, I and I.10 and/or I and I.11.

100. The facts of paragraphs J and J.1.

101. The facts of paragraphs K and K.2.

102. The facts of paragraphs L and L.1 and/or L and L.5.

103. The facts of paragraphs M and M.1. and/or M and M.2.

104. The facts of paragraph N.

105. The facts of paragraph O.

106. The facts of paragraph P.

107. The facts of paragraph Q.

108. The facts of paragraphs R and R.1.

109. The facts of paragraphs R and R.2.

110. The facts of paragraphs R and R.3.

111. The facts of paragraphs R and R.4.

112. The facts of paragraphs R and R.5.

113. The facts of paragraphs R and R.6.

114. The facts of paragraphs R and R.7.

115. The facts of paragraphs R and R.8.

116. The facts of paragraphs R and R.9.

117. The facts of paragraphs R and R.10.

118. The facts of paragraphs R and R.11.

119. The facts of paragraphs R and R.12.

120. The facts of paragraphs R and R.13.

121. The facts of paragraphs R and R.14.

122. The facts of paragraphs R and R.15.

123. The facts of paragraphs R and R.16.

124. The facts of paragraphs R and R.17.

125. The facts of paragraphs R and R.18.

126. The facts of paragraphs R and R.19.

127. The facts of paragraphs R and R.20.

128. The facts of paragraphs S and S.1.

129. The facts of paragraphs S and S.2.

130. The facts of paragraphs S and S.3.

131. The facts of paragraphs S and S.4.

132. The facts of paragraphs S and S.5.

133. The facts of paragraphs S and S.6.

134. The facts of paragraphs S and S.7.

135. The facts of paragraphs T and T.1.

136. The facts of paragraphs T and T.2.

137. The facts of paragraphs T and T.3.

138. The facts of paragraphs T and T.4.

139. The facts of paragraph U.

140. The facts of paragraphs V and V.1.

141. The facts of paragraphs V and V.2.

142. The facts of paragraphs V and V.3.

143. The facts of paragraphs V and V.4.

144. The facts of paragraphs V and V.5.

145. The facts of paragraphs V and V.6.

146. The facts of paragraphs V and V.7.

147. The facts of paragraphs V and V.8.

148. The facts of paragraphs V and V.9.

149. The facts of paragraphs W and W.1.

150. The facts of paragraphs W and W.2.

151. The facts of paragraphs W and W.3.

152. The facts of paragraphs X and X.1.

153. The facts of paragraphs X and X.2.

154. The facts of paragraphs X and X.3.

155. The facts of paragraphs X and X.4.

156. The facts of paragraphs X and X.5.

157. The facts of paragraphs X and X.6.

158. The facts of paragraphs X and X.7.

159. The facts of paragraphs X and X.8.

160. The facts of paragraphs X and X.9.

161. The facts of paragraphs X and X.10.

162. The facts of paragraphs Y and Y.1.

163. The facts of paragraphs Y and Y.2.

164. The facts of paragraphs Z and Z.1.

165. The facts of paragraphs Z and Z.2.

166. The facts of paragraphs Z and Z.3.

167. The facts of paragraphs AA and AA.1.

168. The facts of paragraphs AA and AA.2.

ONE HUNDRED SIXTY NINTH AND
ONE HUNDRED SEVENTIETH SPECIFICATIONS
GUARANTEEING SATISFACTION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(34) by guaranteeing that satisfaction or a cure will result from the performance of professional services, as set forth in:

169. The facts of paragraphs F and F.3.

170. The facts of paragraphs I and I.2.

ONE HUNDRED SEVENTY FIRST THROUGH
ONE HUNDRED NINETY FIFTH SPECIFICATIONS
ADVERTISING NOT IN THE PUBLIC INTEREST

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(27) by advertising not in the public interest, as set forth in:

171. The facts of paragraphs E and E.2.

172. The facts of paragraph O.

173. The facts of paragraph P.

174. The facts of paragraph Q.

175. The facts of paragraphs R and R.4.

176. The facts of paragraphs R and R.6.

177. The facts of paragraphs R and R.7.

178. The facts of paragraphs R and R.12.

179. The facts of paragraphs R and R.17.

180. The facts of paragraphs R and R.18.

181. The facts of paragraphs R and R.19.

182. The facts of paragraphs R and R.20.

183. The facts of paragraphs S and S.1.

184. The facts of paragraphs S and S.2.

185. The facts of paragraphs S and S.4.

186. The facts of paragraphs S and S.6

187. The facts of paragraphs S and S.7.

188. The facts of paragraphs V and V.2.

189. The facts of paragraphs V and V.5.

190. The facts of paragraphs V and V.6.

191. The facts of paragraphs Z and Z.1.

192. The facts of paragraphs Z and Z.2.

193. The facts of paragraphs Z and Z.3.

194. The facts of paragraphs AA and AA.1.

195. The facts of paragraphs AA and AA.2.

ONE HUNDRED NINETY SIXTH THROUGH
ONE HUNDRED NINETY NINTH SPECIFICATIONS
LACK OF PROPER CONSENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(26) by performing professional services which have not been duly authorized by the patient or his or her legal representative as set forth in:

196. The facts of paragraphs B and B.2, B and B.3 and/or B and B.9.

197. The facts of paragraphs F and F.3 and/or F and F.4.

198. The facts of paragraphs G and G.2.

199. The facts of paragraphs H and H.4.

TWO HUNDREDTH THROUGH
TWO HUNDRED TWELFTH SPECIFICATIONS
VIOLATION OF PUBLIC HEALTH LAW 2805-k

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(14) by not providing the information required by Public Health Law section 2805-k when he was seeking a grant or renewal of privileges, as set forth in:

200. The facts of paragraphs R and R.2.
201. The facts of paragraphs R and R.3.
202. The facts of paragraphs R and R.5.
203. The facts of paragraphs R and R.13.
204. The facts of paragraphs R and R.14.
205. The facts of paragraphs S and S.3
206. The facts of paragraphs S and S.4.
207. The facts of paragraphs T and T.1.
208. The facts of paragraphs T and T.2.
209. The facts of paragraphs T and T.4.
210. The facts of paragraphs V and V.2.
211. The facts of paragraphs V and V.4.
212. The facts of paragraphs V and V.5.

TWO HUNDRED THIRTEENTH THROUGH
TWO HUNDRED TWENTY FIFTH SPECIFICATIONS
FILING FALSE REPORTS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by filing false reports, as set forth in:

213. The facts of paragraphs R and R.2.
214. The facts of paragraphs R and R.3.

215. The facts of paragraphs R and R.5.

216. The facts of paragraphs R and R.13.

217. The facts of paragraphs R and R.14.

218. The facts of paragraphs S and S.3.

219. The facts of paragraphs S and S.4.

220. The facts of paragraphs T and T.1.

221. The facts of paragraphs T and T.2.

222. The facts of paragraphs T and T.4.

223. The facts of paragraphs V and V.2.

224. The facts of paragraphs V and V.4.

225. The facts of paragraphs V and V.5.

DATED: October 9, 2002

Albany, New York

BRIAN M. MURPHY
Chief Counsel
Bureau of Professional
Medical Conduct