STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

October 29, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Marvin L. Tenzer, P.C.
305 Broadway
New York, New York 10087

Arun Sirohi, M.D.
145 Sherwood Drive
Ramsey, New Jersey 07445

RE: In the Matter of Arun Sirohi, M.D.

Dear Mr. Stein, Mr. Tenzer and Dr. Sirohi:

Enclosed please find the Determination and Order (No. BPMC-92-96) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than 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), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

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

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

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

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
ARUN SIROHI, M.D.	:	ORDER

ORDER NO. BPMC-92-96

LINDA D. LEWIS, M.D., Chairperson, MS. OLIVE JACOB, and THOMAS J. SINATRA, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the hearing committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **ELLEN B. SIMON, ESQ.,** Administrative Law Judge, served as Administrative Officer for the hearing committee.

After consideration of the entire record, the hearing committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence and with incompetence, each on more than one occasion, and by reason of having ordered excessive tests.

The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing dated:	June 16, 1992
Amended Statement of Charges:	July 10, 1992
Pre-hearing Conference:	June 26, 1992
Hearing dates:	July 10, 1992 July 17, 1992 August 7, 1992 August 21, 1992 August 24, 1992
Deliberation date:	September 30, 1992
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Paul Stein, Esq. Associate Counsel
Respondent appeared by:	Marvin L. Tenzer, P.C. 305 Broadway New York, New York

MOTIONS:

1. July 8, 1992: Pre-hearing motion for an adjournment on behalf of the Respondent by Marvin L. Tenzer, Esq. - **DENIED**

2. July 10, 1992: Petitioner's motion to amend the Statement of Charges to include an additional factual allegation in the existing charges of practicing with negligence and incompetence - **GRANTED**

3. August 24, 1992: Petitioner's motion to further amend the Amended Statement of Charges to conform to proof as to the street address of Respondent's place of practice - **GRANTED**

WITNESSES:

For the Petitioner	John Graney, M.D.
For the Respondent	George E. Woody, M.D.

FINDINGS OF FACT

Numbers in parentheses 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.

GENERAL FINDINGS

1. Arun Sirohi, M.D., the Respondent, was authorized to practice medicine in New York State on July 30, 1987 by the issuance of license number 171421 by the New York State Education Department. (Dept.'s Ex. 2).

2. The Respondent currently practices medicine in Pennsylvania (Resp.'s Ex. B; Tr. 537).

FINDINGS OF FACT AS TO PATIENT A

3. On March 5, 1988, Patient A visited Respondent, who noted Patient A's complaint of poor sleep and diagnosed him as having a peptic ulcer and back pain. Respondent prescribed Valium, Zantac (an H2 blocker), and a non-steroidal anti-inflammatory drug for Patient A's back pain. (Dept.'s Ex. 4-A)

4. On April 27, 1988, Patient A returned to the office of Respondent, who again prescribed Valium for the patient. (Dept.'s Ex. 4-A)

5. Respondent failed to note that he evaluated the risk to Patient A of the continued use of Valium (Dept.'s Ex. 4-A) but did make such evaluation (Tr. 616-617, 721-722)

6. On March 5, 1988, Respondent noted that Patient A was a 42 year old male (Dept.'s Ex. 4-A), and on the same date a spirometry was performed on a 42 year old male. (Dept.'s Ex. 4-AA)

7. On March 7, 1988, blood tests wee performed on Patient A, and on March 23, 1988 the testing laboratory reported the results of those tests, including a low platelet count. (Dept.'s Ex. 4-AA)

8. On Patient A's return visit of April 27, 1988, Respondent failed to note that he followed up on the laboratory test indication of low platelets. (Dept.'s Ex. 4-A)

CONCLUSIONS AS TO PATIENT A

1. Respondent diagnosed Patient A's peptic ulcer but determined that it was inactive. He then prescribed a non-steroidal anti-inflammatory drug for Patient A's back pain. As a precautionary measure, Respondent also prescribed an H2 blocker. (Tr. 562-563, 721)

2. Respondent evaluated the risk of Patient A's

continued use of Valium without noting it and prescribed low doses, without refills (Dept.'s Ex. 4-A; Tr. 614-617, 721). Respondent's prescription of Valium for Patient A's anxiety was not inappropriate. (Tr. 614)

3. There is insufficient evidence to conclude that Respondent ordered every test performed on Patient A (Tr. 798-800); in any case, Patient A's record indicates an adequate basis for those tests that were performed that indicated abnormalities. (Dept.'s Ex. 4-A)

4. Respondent failed to follow up on the laboratory report of Patient A's low platelet count, which Respondent himself circled. (Dept.'s Ex. 4-A)

FINDINGS OF FACT AS TO PATIENT B

9. On March 7, 1988, Patient B visited Respondent, who noted Patient B's complaints of poor sleep, foot pain, phlegm, and a rash on his penis and diagnosed Patient B as having anxiety and peptic ulcer disease. Respondent also noted Patient B's history, including that he had used tobacco, alcohol, and intravenous drugs, that he had no allergies, that he had a stab wound of the lung, and that he had had one or more operations. Respondent prescribed for Patient B Valium, a non-steroidal anti-inflammatory drug, and Zantac. (Dept.'s Ex. 4-B)

10. Respondent did not document that he examined Patient B's penis for a rash, although such a rash was one

of Patient B's chief complaints. (Dept.'s Ex 4-B)

11. On May 13, 1988, Patient B returned to the office of Respondent, who again noted the patient's anxiety and again prescribed Valium. (Dept.'s Ex. 4-B)

12. Respondent failed to note that he evaluated the risk to Patient B of the continued use of Valium (Dept.'s Ex. 4-B) but did make such evaluation. (Tr. 616-617, 721-722)

13. Respondent failed to note that he evaluated the risk to Patient B of the continued use of Valium (Dept.'s Ex. 4-B) but did make such evaluation. (Tr. 616-617, 721-722)

14. On March 7, 1988, blood tests were performed on Patient B, and on March 23, 1988, the testing laboratory reported the results of those tests, including a normal iron level. (Dept.'s Ex. 4-B)

15. On March 7, 1988, Respondent noted that Patient B was a 31 year old male (Dept.'s Ex. 4-B), and on the same date a spirometry was performed on a 31 year male. (Dept.'s Ex. 4-BB)

16. On May 13, 1988, an echocardiogram and an abdominal ultrasound examination were performed on Patient B, with normal results reported. (Dept.'s Ex. 4-B)

CONCLUSIONS AS TO PATIENT B

1. Respondent's documented history of Patient B is not exhaustive, but it is adequate.

2. Although Respondent noted Patient B's complaint of a rash on his penis, Respondent failed to examine the patient for such a rash.

3. The laboratory report of Patient B's blood tests showed a normal level of iron; there was therefore no iron deficiency to be either noted in the record or treated.

4. Respondent diagnosed Patient B's peptic ulcer but determined that it was inactive. He then prescribed a non-steroidal anti-inflammatory drug and, as a precautionary measure, an H2 blocker as well (Tr. 562-563, 721). Accordingly, Respondent's prescription of a non-steroidal anti-inflammatory drug for Patient foot pain was not inappropriate.

5. Because Respondent evaluated the risk of Patient B's continued use of Valium and prescribed low doses without refills, Respondent's prescription of Valium for Patient B was not inappropriate. (Tr. 614-617, 721-722)

6. There is insufficient evidence to conclude that Respondent ordered every test performed on Patient B (Tr. 798-800); in any case, Patient B's record indicates an adequate basis for those tests that were performed that indicate abnormalities. (Dept.'s Exs. 4-B, 4-BB)

7. There were no medically significant laboratory test

results that required any follow-up with Patient B. (Dept.'s Exs. 4-B, 4-BB)

FINDINGS OF FACT AS TO PATIENT C

17. On September 30, 1988, Patient C visited Respondent, who noted her complaints of sleep disorder, bad ulcer, phlegm, and fever and diagnosed Patient C as having bronchitis, peptic ulcer disease, and anxiety. Respondent examined the patient and noted diffuse wheezing in her chest. Respondent also noted Patient C's history, including that she had used tobacco, alcohol, and intravenous drugs. Respondent further noted that Patient C had previously taken Valium, Zantac, Keflex (cephalexin) (Tr. 307 and had used a pump for asthma. Respondent prescribe for Patient C Zantac, Keflex, and Valium. (Dept.'s Ex. 4-C)

18. On October 14, 1987, Patient C returned to the office of Respondent, who recorded, inter alia, the patient's runny nose, phlegm, and diffuse wheezing, and again noted her bronchitis, with an upper respiratory infection, peptic ulcer disease, and anxiety. Respondent also noted that Patient C reported that the pharmacist had not given her Keflex. Respondent again prescribed for Patient C Zantac, Keflex, and Valium. (Dept.'s Ex. 4-C)

19. On October 29, 1987, Patient C again visited Respondent, who noted that the patient had clear lungs but needed ulcer and nerve medication. Respondent again noted

the patient's anxiety. Respondent again prescribed Zantac and Valium for Patient C and added, among other prescriptions, a non-steroidal anti-inflammatory drug and Proventil, an albuterol. (Dept.'s Ex. 4-C; Tr. 513).

20. Respondent did not record having performed a rectal examination of Patient C or having checked her stool for blood. (Dept.'s Ex. 4-C)

21. Respondent failed to note that he evaluated the risk to Patient C of the continued use of Valium (Dept.'s Ex. 4-C) but in fact made such evaluation (Tr. 616-617, 721-722)

22. On September 30, 1987, Respondent noted that Patient C was a 39 year old female (Dept.'s Ex. 4-C), and on the same date a spirometry was performed on a 39 year old female. That test indicated a mild reduced FVC (Dept.'s Ex 4-CC). Reduced FVC is indicated under "Labs checked" on Respondent's record of Patient C's October 29, 1987 visit. (Dept.'s Ex. 4-C)

CONCLUSIONS AS TO PATIENT C

1. Respondent obtained and noted an adequate history of Patient C while he was treating her.

2. Respondent's physical examination of Patient C was inadequate because he failed to perform a rectal examination or examine her stool for blood after having recorded her complaint of a "bad ulcer".

3. Respondent diagnosed Patient C as having symptoms of both bronchitis and asthma, and therefore Respondent's prescription of an albuterol for Patient C was appropriate.

4. Respondent noted in his September 30, 1987 examination of Patient C that she had previously taken Keflex, and he prescribed it for her again. During Patient C's October 14, 1987 examination, Respondent recorded that the patient still had yellow phlegm; he also noted, however, that the patient had told him that the pharmacist had not given her Keflex, and he again prescribed Keflex for her. By the time Respondent examined Patient C on October 29, 1987, he noted that her lungs were clear, and he did not then prescribe Keflex. Respondent's prescription of cephalexin for Patient C was appropriate.

5. Respondent diagnosed Patient C's peptic ulcer but determined that it was inactive. He then prescribed a non-steroidal anti-inflammatory drug and, as a precautionary measure, an H2 blocker as well (Tr. 562-563, 721). Accordingly, Respondent's prescription of a non-steroidal anti-inflammatory drug for Patient C was not inappropriate.

6. Respondent evaluated the risk of Patient C's continued use of Valium and prescribed low doses without refills (Dept.'s Ex. 4-C; Tr. 614-617, 721). Respondent's prescription of Valium for Patient C's anxiety was not inappropriate. (Tr. 614)

7. Having diagnosed and recorded Patient C's peptic

ulcer disease and complaint of a "bad ulcer", Respondent should have performed a rectal examination and examined Patient C's stool for blood; he did neither. As to other tests, there is insufficient evidence to conclude that Respondent ordered every test performed on Patient C (Tr. 798-800), but in any case, many rheumatological tests were performed that were related to Patient C's asthma, and Patient C's record indicates an adequate basis for those tests that were performed that indicated abnormalities.

8. Respondent noted in his October 14 and October 29, 1987 examinations of Patient C that he had checked the "labs". His records indicate that his reaction to the laboratory results was appropriate.

FINDINGS OF FACT AS TO PATIENT D

23. On March 10, 1988, Patient D visited Respondent, who noted Patient D's complaints of poor sleep, ulcer, anxiety, and back pain, took the patient's medical history, and examined him. Among Respondent's diagnoses was "decreased air entry" in the lungs. Respondent's prescriptions for Patient D included Valium, Zantac, and a non-steroidal anti-inflammatory drug. (Dept.'s 4-D)

24. On March 28, 1988, Respondent again saw Patient D and again prescribed Valium, Zantac, and a non-inflammatory drug. (Dept.'s Ex. 4-D)

25. On April 12, 1988, Patient D returned to the

office of Respondent who noted that Patient D felt "all right" but also noted the patient's poor sleep and included among his diagnoses anxiety. Respondent's prescriptions again included Valium and Zantac. (Dept.'s Ex. 4-D)

26. On May 20, 1988, Patient D again visited Respondent, who noted that he had checked the results of Patient D's laboratory tests, including a normal EKG. Respondent also noted Patient D's complaint of abdominal pain and that a sonogram was advised. Among Respondent's prescriptions for Patient D were Valium, Zantac, and a non-steroidal anti-inflammatory drug. (Dept.'s Ex. 4-D)

27. Respondent evaluated the risk to Patient D of continued use of Valium (Tr. 616-617, 721-722) but failed to note any such evaluation. (Dept.'s Ex. 4-D)

28. Respondent did not record having performed a rectal examination or having checked Patient D's stool for blood. (Dept.'s Ex. 4-D)

29. On March 10, 1988, Respondent noted that Patient D was a 48 year old male (Dept.'s Ex. 4-D), and on the same date a spirometry with normal results was performed on a 48 year old male. (Dept.'s Ex. 4-DD)

30. Blood tests were performed on Patient D on March 10, 1988, and the results, showing normal iron and slightly elevated liver enzymes, were reported on April 1, 1988 (Dept.'s Ex. 4-D). On April 12, 1988, sonograms of the liver and pancreas were performed on Patient D, with normal

or inconclusive results, and on the same date Patient D had an echocardiogram, with normal results (Dept.'s Ex. 4-D). On May 20, 1988, an EKG was performed on Patient D. (Dept.'s Ex. 4-DD).

CONCLUSIONS AS TO PATIENT D

1. Respondent obtained and noted an adequate history of Patient D while he was treating him.

2. Respondent's physical examination of Patient D was inadequate because he failed to perform a rectal examination or examine his stool for blood after he diagnosed Patient D's peptic ulcer disease.

3. Respondent reviewed Patient D's March 10, 1988 blood tests, as noted upon Patient D's March 28, 1988 visit, and reacted appropriately to their results.

4. There is insufficient to conclude that Respondent ordered every test performed on Patient D (Tr. 798-800), but in view of Respondent's diagnoses of Patient D, there is an adequate basis for at least those tests that were performed that indicate abnormalities.

5. Respondent diagnosed Patient D's peptic ulcer but determined that it was inactive. He then prescribed a non-steroidal anti-inflammatory drug for Patient D's back pain and, as a precautionary measure, an H2 blocker as well (Tr. 562-563, 721). Accordingly, Respondent's prescription of a non-steroidal anti-inflammatory drug for Patient D was not

inappropriate.

6. Respondent evaluated the risk to Patient D of the continued use of Valium and prescribed low doses without refills (Dept.'s Ex. 4-D; Tr. 614-617, 721). Respondent's prescription of Valium for Patient's D's anxiety was not inappropriate. (Tr. 614)

7. There is insufficient evidence to conclude that Respondent ordered every test performed on Patient D (Tr. 798-800); in any case, Patient D's record indicates an adequate basis for those tests that were performed that indicate abnormalities. (Dept.'s Exs. 4-D, 4-DD)

8. The first significant abnormal result of tests performed on Patient D was the elevated liver enzymes reported on April 1, 1988. That result was appropriately followed up with a liver sonogram, performed on Patient D on April 12, 1988, which indicated no liver abnormality.

FINDINGS OF FACT AS TO PATIENT E

31. On March 5, 1988, Patient E visited Respondent, who took Patient E's history, noted his complaints of back pain, ulcer, and anxiety and diagnosed, inter alia, decreased air entry in the lungs. Respondent's prescriptions for Patient E included Valium, Zantac, and a non-steroidal anti-inflammatory drug. (Dept.'s Ex. 4-E)

32. On March 26, 1988, Patient E returned to the office of Respondent, who noted that Patient E's chest was

clear and again included among his prescriptions Valium, Zantac, and a non-steroidal anti-inflammatory drug. (Dept.'s Ex. 4-E)

33. Respondent evaluated the risk to Patient E of the continued use of Valium (Tr. 616-617, 721-722) but failed to note any such evaluation. (Dept.'s Ex. 4-E)

34. On March 7, 1988, many blood tests were performed on Patient E, and the results, including a positive RPR (syphilis serology), were reported on March 23, 1988, except for a follow-up FTA positive result, which was reported on March 29, 1988. There is no notation on the chart of Patient E's next visit, on March 26, 1988 that Respondent checked any laboratory reports. (Dept.'s Ex. 4-E)

CONCLUSIONS AS TO PATIENT E

1. Respondent obtained and noted an adequate history of Patient E while he was treating him (Dept.'s Ex. 4-E)

2. Respondent conducted and noted an adequate physical examination of Patient E. (Dept.'s Ex. 4-E)

3. Patient E's record indicates that positive syphilis results, including a positive FTA, were unavailable to Respondent at the time of Patient E's last visit; there is no notation that Respondent checked laboratory tests. There is insufficient evidence to conclude that Respondent ordered every test performed on Patient E, and in fact there were inappropriate blood tests ordered. There is also

insufficient evidence to conclude that the positive test results were valid or, even if they were, that Respondent was aware of such results. (Dept.'s Ex. 4-E; Tr. 865, 867)

4. Given Respondent's diagnoses of Patient's back pain, ulcer, and anxiety and Patient E's history of tobacco, alcohol, and intravenous drug use, some tests were appropriate and were performed. (Dept.'s Ex. 4-E)

5. Respondent diagnosed Patient E's peptic ulcer but determined that it was inactive. He then prescribed a non-steroidal anti-inflammatory drug for Patient E's back pain and, as a precautionary measure, an H2 blocker as well (Tr. 562-563, 721). Accordingly, Respondent's prescription of a non-steroidal anti-inflammatory drug for Patient E was not inappropriate.

6. Respondent evaluated the risk to Patient E of the continued use of Valium without noting it and prescribed low doses without refills (Dept.'s Ex. 4-E; Tr. 614-617, 721). Respondent's prescription of Valium for Patient E's anxiety was not inappropriate. (Tr. 614)

7. There is insufficient evidence to conclude that Respondent ordered every test performed on Patient E (Tr. 798-800); in any case, Patient E's record indicates an adequate basis for some of the tests that were performed.

8. There is insufficient evidence to conclude that Respondent failed to follow up on medically significant results of Patient E's laboratory results. Of significance

is the positive FTA reported on March 29, 1988, but there is insufficient proof that Respondent ordered the related blood test and would have been looking for its results, that the positive result was valid, or that, even if it was, Respondent was aware of it at the time of Patient E's last visit on March 26, 1988. (Tr. 865, 867)

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously as follows:

FIRST THROUGH FIFTH SPECIFICATIONS:

(Excessive tests)

SUSTAINED AS TO PARAGRAPHS A, B, C, D AND E

NOT SUSTAINED AS TO PARAGRAPHS A4, B7, C7, D7 and E7

SIXTH SPECIFICATION:

(Negligence on more than one occasion)

SUSTAINED AS TO PARAGRAPHS A, A1 (diagnosis of peptic ulcer), A5, B, B2, B4 (diagnosis of peptic ulcer), C, C2 C3 (diagnosis of bronchitis, prescription of an albuterol), C4 (diagnosis of peptic ulcer), D, D2, D4 (diagnosis of peptic ulcer), E and E4 (diagnosis of peptic ulcer)

NOT SUSTAINED AS TO PARAGRAPHS A1 (inappropriate prescription), A2, A3, B1, B3, B4 (inappropriate prescription), B5-B8, C1, C3 (no diagnosis of asthma, albuterol not indicated, inappropriate prescription of cephalexin), C4 (failed to order tests, inappropriate prescription), C5, C6, C8, D1, D3, D4 (failed to order tests, inappropriate prescription), D5, D6, D8, E1-E6 and E8

SEVENTH SPECIFICATION:

(Incompetence on more than one occasion)

SUSTAINED AS TO PARAGRAPHS A, A1 (diagnosis of peptic ulcer), A5, B, B2, B4 (diagnosis of peptic ulcer), C, C2, C3 (diagnosis of bronchitis, prescription of an albuterol), C4 (diagnosis of peptic ulcer), D, D2, D4 (diagnosis of peptic

ulcer), E, and E4 (diagnosis of peptic ulcer)

NOT SUSTAINED AS TO PARAGRAPHS A1 (inappropriate prescription), A2, A3, A4, B1 , B3, B4 (inappropriate prescription), B5-B8, C1, C3 (no diagnosis of asthma, albuterol not indicated, inappropriate prescription of cephalexin), C4 (failed to order tests, inappropriate prescription), C5-C8, D1, D3, D4 (failed to order tests, inappropriate prescription), D5-D8, E1-E3, E4 (failed to order tests, contraindicated prescription), and E5-E8

EIGHTH THROUGH TWELFTH SPECIFICATIONS:

(Failing to maintain a record)

SUSTAINED AS TO PARAGRAPHS A, B, B2, C, C2, C4 (diagnosed peptic ulcer), D, D2, E and E4 (diagnosed peptic ulcer)

NOT SUSTAINED AS TO PARAGRAPHS A3, A4, B1, B3, B6, B7, C1, C3, C4 (failed to order tests, inappropriate prescription), C6, C7, D1, D3, D4 (failed to order tests, inappropriate prescription), D6, D7, E1-E3, E4 (failure to order tests, contraindicated prescription), E6 and E7

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines that the Respondent should receive a censure and reprimand.

ORDER

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

1. Respondent is censured and reprimanded.

DATED: New York, New York
October 27, 1992

LINDA D. LEWIS, M.D.
Chairperson

MS. OLIVE JACOB
THOMAS J. SINATRA, M.D.

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ARUN SIROHI, M.D.	:	CHARGES

----------X

ARUN SIROHI, M.D., the Respondent, was authorized to practice medicine in New York State on July 30, 1987 by the issuance of license number 171421 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992.

FACTUAL ALLEGATIONS

A. Between on or about March 5, 1988 and April 27, 1988, on two occasions, Respondent treated Patient "A" (patients' names appear in the attached Appendix) for complaints of poor sleep, an ulcer and back pain, at his medical offices at 1035 Grand Concourse, Bronx, New York.

1. In or about March 1988, Respondent diagnosed Patient A as having a peptic ulcer. Nevertheless,

Respondent inappropriately prescribed non-steroidal anti-inflammatory drugs.

2. At each visit made throughout the period Respondent inappropriately prescribed Valium.

3. Respondent failed to evaluate the risk to Patient A of the continued use of Valium or to note any such evaluation.

4. At various times during 1988, Respondent inappropriately performed expensive blood tests on Patient A as well as spirometry. Respondent failed to note any history, complaint, or physical findings which indicated such tests and, in fact, such tests were unnecessary.

B. Between on or about March 7, 1988 and May 13, 1988, on two occasions, Respondent treated Patient "B" for complaints of anxiety, and for a peptic ulcer and foot pain, at his medical offices at 1035 Grand Concourse, Bronx, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. In or about March, 1988, Respondent received blood test results indicating Patient B suffered from iron deficiency. Respondent failed to note this in the record and failed to treat the iron deficiency.

4. In or about March, 1988, Respondent diagnosed Patient B as having a peptic ulcer. Nevertheless, Respondent inappropriately prescribed non-steroidal anti-inflammatory drugs.

5. At each visit made throughout the period Respondent inappropriately prescribed Valium.

6. Respondent failed to evaluate the risk to Patient B of the continued use of Valium or to note any such evaluation.

7. At various times during 1988, Respondent inappropriately performed expensive blood tests on Patient B as well as spirometry, an echocardiogram, and an abdominal ultrasound examination. Respondent failed to note any history, complaints, or physical

findings which indicated such tests and, in fact, such tests were unnecessary.

C. Between on or about September 30, 1987 and October 29, 1987, on three occasions, Respondent treated Patient "C" for complaints of sleep disorder, ulcer, phlegm and fever, at his medical office at 1035 Grand Concourse Bronx, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. In or about September, 1987, Respondent diagnosed Patient C as having bronchitis. There is no clear history of diagnosis of asthma in the record. Nevertheless, Respondent prescribed Albuterol, an asthma inhalant, not indicated for treatment of bronchitis. Respondent also inappropriately prescribed cephalexin, an antibiotic previously taken by Patient C, that had not cured her symptoms.

4. In or about September, 1987 Respondent diagnosed Patient C as having a peptic ulcer. Nevertheless, Respondent failed to order, perform and note appropriate laboratory and diagnostic tests and procedures. Further, Respondent inappropriately prescribed non-steroidal anti-inflammatory drugs.

5. At each visit made throughout the period Respondent inappropriately prescribed Valium.

6. Respondent failed to evaluate the risk to Patient C of the continued use of Valium or to note any such evaluation.

7. At various times during 1987, Respondent inappropriately performed expensive blood tests on Patient C, as well as an EKG, and an abdominal ultrasound examination. Respondent failed to note any condition which indicated such tests.

D. Between on or about March 10, 1988 and May 20, 1988, on four occasions, Respondent treated Patient "D" for complaints of sleep disorder, ulcer, anxiety and back pain, at his medical offices at 1035 Grand Concourse, Bronx, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. Respondent failed throughout the period of treatment to follow up on abnormal blood test results.

4. In or about March 1988, Respondent diagnosed Patient D as having a peptic ulcer. Nevertheless, Respondent failed to order, perform and note appropriate laboratory and diagnostic tests and procedures. Further, Respondent inappropriately prescribed non-steroidal anti-inflammatory drugs.

5. At each visit made throughout the period Respondent inappropriately prescribed Valium.

6. Respondent failed to evaluate the risk to Patient D of the continued use of Valium or to note any such evaluation.

7. At various times during 1988, Respondent inappropriately performed expensive blood tests on

Patient D as well as spirometry, an EKG, an echocardiogram and a sonogram of the liver. Respondent failed to note any history, complaints, or physical findings which indicated such tests and, in fact, such tests were unnecessary.

E. Between on or about March 5, 1988 and March 26, 1988, on two occasions, Respondent treated Patient "E" for complaints of back pain, ulcer, and anxiety, at his medical offices at 1035 Grand Concourse, Bronx, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. In or about March, 1988, Respondent received blood test results for Patient E that were positive for syphilis. Respondent failed to appropriately follow-up on such results, and to note any such follow-up.

4. In or about March 1988, Respondent diagnosed Patient E as having a peptic ulcer. Nevertheless, Respondent failed to order, perform and note appropriate laboratory and diagnostic tests and procedures. Further, Respondent prescribed non-steroidal anti-inflammatory drugs which were contraindicated.

5. At each visit made throughout the period Respondent inappropriately prescribed Valium.

6. Respondent failed to evaluate the risk to Patient E of the continued use of Valium or to note any such evaluation.

7. At various times during 1988, Respondent inappropriately performed expensive blood tests on Patient. Respondent failed to note any condition which indicated such tests and, in fact, such tests were unnecessary.

F. On or about February 25, 1992, after a full hearing pursuant to Section 519.4 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York appealing from a determination of the New York State Department of Social Services to exclude Respondent from the

Medical Assistance for Needy Persons Program (the Medicaid Program) for two years, the determination to exclude Respondent from participation in the Medicaid Program for two years was affirmed.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

EXCESSIVE TESTS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(35) (McKinney Supp. 1992), in that he ordered excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient, Petitioner specifically charges:

1. The facts in Paragraphs A and A4.

2. The facts in Paragraphs B and B7.

3. The facts in Paragraphs C and C7.

4. The facts in Paragraphs D and D7.

5. The facts in Paragraphs E and E7.

SIXTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed at least two of the following:

6. The facts in Paragraphs A and A1-3; B and B1-6, C and C1-6; D and D1-6; and/or E and E1-6.

SEVENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed at least two of the following:

7. The facts in Paragraphs A and A1-4; B and B1-7; C and C1-7; D and D1-7; and/or E and E1-7.

EIGHTH THROUGH TWELFTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1992), in that he failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Specifically, Petitioner charges:

8. The facts in Paragraphs A and A3, 4.

9. The facts in Paragraphs B and B1-3, 6, 7.

10. The facts in Paragraphs C and C1-4, 6, 7.

11. The facts in Paragraphs D and D1-4, 6, 7.

12. The facts in Paragraphs E and E1-4, 6, 7.

THIRTEENTH SPECIFICATION

PREVIOUS ADJUDICATION OF VIOLATION OF STATE REGULATION

Respondent is charged pursuant to N.Y. Educ. Law Section 6530(9)(c) (McKinney Supp. 1992) with having been found guilty in

an adjudicatory proceeding of violating a state regulation, pursuant to a final decision or determination, when no appeal is pending, and when the violation would constitute professional misconduct pursuant to N.Y. Educ. Law Section 6530 (McKinney Supp. 1992), including Section 6530(2) practicing the profession fraudulently, and/or Section 6530(3) practicing the profession with negligence on more than one occasion, and/or Section 6530(5) practicing the profession with incompetence on more than one occasion, and/or Section 6530(32) failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, and/or Section 6530(35) ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient. Specifically, Petitioner charges:

13. The facts in Paragraph F.

DATED: New York, New York
June 16, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct