

**These charges are only allegations which
may be contested by the licensee in an
Administrative hearing.**

IN THE MATTER
OF
NASIM HAIDER, M.D.

STATEMENT
OF
CHARGES

NASIM HAIDER, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 6, 1994, by the issuance of license number 197993 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent is subject to BPMC Order No. 04-285 effective December 20, 2004 which imposed a penalty of 36 months suspension, with the first 4 months served as actual period of suspension and the last 32 months stayed, 36 months' probation, a fine of \$10,000 and as a condition a permanent limitation on his license requiring Respondent to treat and or consult female patients only in the presence of a female chaperone. Pursuant to said order all chaperones must be proposed by Respondent and approved by OPMC. Respondent is required as a condition of said order to cause the chaperone to make a notation in the patient record acknowledging their presence at each examination of a female patient and to maintain a chaperone log which documents each patient contact that is chaperoned. Respondent is required to produce said logs upon the request of OPMC. Said order further required Respondent as a condition to cooperate fully with the office of Professional Medical Conduct in its administration and enforcement of said order and its investigation of matters concerning Respondent. Respondent is also required pursuant to a condition of said order to verify compliance with the terms of the order. Respondent violated the terms of BPMC Order No. 04-285 in that :

1. Respondent submitted to OPMC a declaration affirming that during the period July 7, 2011, through October 7, 2012, Respondent was in compliance with the order and had not been arrested, charged or convicted in any criminal or civil matter. In fact Respondent knew that on March 8, 2012, he had been arrested on the charges of Forcible Touching in violation of Penal Law 130.52 and Sexual Abuse in the 3rd Degree violation of Penal Law 130.55. Respondent knew that his statement to OPMC was false and intended to deceive.
2. On November 13, 2013, during a site visit to Respondent's office at 111-21 Roosevelt Avenue Corona New York (private office) OPMC investigators requested chaperone logs for the period 2012-2013. Respondent was not able to produce such logs.
3. The Respondent examined and/or treated the following patients (all patient are identified in appendix A attached) on one or more of the following dates noted in the medical records or on other dates not noted in the medical records, without a chaperone present, without an approved chaperone present and/ or without causing a chaperone to note her presence in the patients' medical record.
 - a. Patient A, November 13, 2013;
 - b. Patient B, August 3, 2010, May 17, 2011, and/or November 13, 2013;
 - c. Patient C, June 28, 2013 and/or July 8, 2013;
 - d. Patient D, January 11, 2009, November 8, 2009, January 30, 2010, June 20, 2010, July 31, 2010, April 26, 2011, November 9, 2011, June 13, 2012, October 19, 2012 June 20, 2013, , June 27, 2013, July 8, 2013, August 30, 2013, September 15, 2013, and/or November 4, 2013;
 - e. Patient E, August 01, 2010, November 27, 2012, February 23, 2013, August 10, 2013, October 5, 2013, and/or November 19, 2013
 - f. Patient F, November 14, 2007, October 13,2009, May 11, 2011,and/ or May 26, 2013;
 - g. Patient I, October 13, 2013,June 6, 2014, and/or June 22, 2014;

- h. Patient H, February 2012
- i. Patient J October 2013

B. Respondent examined Patient A at his private office on November 13, 2013 for an immigration physical without a chaperone present.

- 1. Respondent placed his hands and rubbed Patient A's lower abdomen, groin, hips and / or buttocks for no legitimate medical purpose
- 2. Respondent falsely advised Patient A that she required a pelvic sonogram which he would provide in his office which she declined.
- 3. Respondent asked Patient A if she would dance for him.
- 4. Respondent telephoned Patient A and told her if she was contacted by the Health Department to lie and tell the Department that there was a female chaperone present during her examination on November 13, 2013.
- 5. Respondent knowingly and willfully submitted a medical record to OPMC which he falsely purported to have been created on November 15, 2013. Respondent knew said record was not created on the alleged date and he intended to deceive

C. Respondent treated Patient C, who had a history of Hepatitis, at his private office on or about June 28, 2013 and on or about July 8, 2013. Respondent's care and treatment of Patient C deviated from acceptable medical standards in that he:

- 1. Failed to obtain and document adequate full or focused history.
- 2. Failed to conduct or document adequate full or focused physical examination.
- 3. Failed to adequately follow-up on and/or treat the patient's:
 - a. elevated H-Pylori;
 - b. elevated AST, ALT and/or history of Hepatitis;
 - c. abnormal laboratory data.
 - d. Complaints of epigastric pain
- 4. Failed to maintain an adequate medical record.

D. Respondent treated Patient D at his private office from on or about January 11, 2009, through on or about November 4, 2013. Respondent's care and treatment of Patient D deviated from acceptable medical conduct in that he:

1. Failed to obtain and document adequate full or focused history.
2. Failed to conduct or document adequate full or focused physical examination.
3. Failed to adequately follow-up on and /or treat the patient's:
 - a. complaint of dysuria;
 - b. complaint related to shoulder pain;
 - c. report to Respondent that she had been treated in the ER for Kidney stones;
 - d. complaint of back pain;
 - e. complaint of breast pain;
 - f. rash;
 - g. CT of head
 - h. complaint of headache.
4. Failed to follow up on a radiologist's recommendation for a breast sonogram
5. Failed to maintain an adequate medical record

E. Respondent provided care and treatment to Patient E at his private office between on or about August 1, 2010, and November 19, 2013. Respondent's care and treatment of Patient E deviated from acceptable medical practice in that he:

1. Failed to obtain and document adequate full or focused history.
2. Failed to conduct or document adequate full or focused physical examination.
3. Failed to adequately follow-up on and/or treat the patient's complaint of rectal bleeding
4. Failed to adequately follow-up on and/or treat the patient's complaint of rash
5. Diagnosed the Patient's complaint's as hemorrhoids on October 5, 2013, without performing a rectal exam or following up on his plan for a colonoscopy.
6. Failed to maintain an adequate medical record

F. Patient F was treated by the Respondent in his private office between on or about November 5, 2007, and September 5, 2013. Respondent's care and treatment of Patient F deviated from acceptable medical standards in that he:

1. Failed to obtain and document adequate full or focused history.
2. Failed to conduct or document adequate full or focused physical examination.
3. Failed to adequately follow-up on and/or treat the patient's:
 - a. complaints of epigastric pain and diarrhea;
 - b. complaint of swelling of the neck and noted swelling of jaw above the neck;
 - c. abnormal lab results reported on September 4, 2013.
4. Inappropriately prescribed Ranitidine and/or Diflucan without obtaining and/or documenting sufficient clinical information to support his prescribing
5. Inappropriately administered a Depo-Provera injection without performing a gynecological examination and/or obtaining sufficient gynecological and/or medical history, and/or documenting that he did.
6. Failed to appropriately evaluate the patient for cellulitis.
7. Failed to maintain an adequate medical record

G. Respondent treated Patient G a 72 year old women in his private office on approximately 9 occasions between May 7, 2012, and July 17, 2013. Respondent's care and treatment of Patient G deviated from acceptable medical standards in that he:

1. Failed to obtain and document adequate full or focused history.
2. Failed to conduct or document adequate full or focused physical examination.
3. Failed to adequately follow-up on and/or treat the patient's:
 - a. complaint of epigastric pain;
 - b. complaints of occasional palpitations;
 - c. noted diagnoses of elevated cholesterol and dyspepsia;
 - d. abnormal EKG.
 - e. Complaints of cough

4. On May 7, 2012, and November 27, 2012, inappropriately diagnosed upper respiratory infection with history of chronic bronchitis and prescribed Z-Pack without obtaining or documenting the patient's temperature.
5. On January 3, 2013, performed an EKG on Patient the patient and failed to accurately interpret the EKG.
6. Respondent failed to note and/or appropriately address abnormalities documented by the radiologist in the chest x-ray report dated July 12, 2013
7. Failed to maintain an adequate medical record.

H. Respondent treated Patient H on or about February 2012 for an immigration physical, and subsequently employed Patient H as an office worker in his medical practice between on or about February 2012, and on or about March 2, 2012. On March 2, 2012, Respondent, in his private medical office, without the consent of Patient H grabbed her, exposed his penis, pulled her toward him, attempted to kiss her, and/or put her hand on his penis, and touched her buttocks and/or breast.

I. Respondent treated Patient I on several occasions between October 2013 and June 2014. Respondent's care and treatment of Patient I deviated from acceptable medical standards in that he:

1. Failed to obtain and document adequate full or focused history.
2. Failed to conduct or document adequate full or focused physical examination
3. On or about June 22 2014 during the course of a physical examination Respondent rubbed his penis against Patient I's arm.

J. On or about November 13, 2013 Respondent maintained conditions in his medical office which violated scientifically accepted infection control practices in that :

1. In Respondent's examination room, there was an open jar containing used lancets;

2. In Respondent's examination room he maintained container labeled "pathological waste," but which had no bag or liner;
3. Respondent's examination room was dirty and unsanitary, the hand washing sink was obstructed with clutter and there were no paper towels in the dispenser.
4. In the room where blood was drawn there was a large open container full of used sharps.
5. In the room where blood was drawn the large open sharps container and garbage container blocked the hand washing sink
6. Respondent's patient waiting room was dirty and unsanitary.

K. On or about November 13, 2013 and/or September 28, 2016 Respondent maintained a refrigerator in the office that did not have any thermometer monitoring temperature and/or maintained a refrigerator that was not properly sealed and contained vaccines, tuberculin purified protein derivative and/or specimens collected from patients. .

SPECIFICATION OF CHARGES
FIRST THROUGH THIRD SPECIFICATIONS
VIOLATING ANY TERM OF PROBATION OR CONDITION OR LIMITATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(29) by violating any term of probation or condition or limitation imposed on the licensee pursuant to section two hundred thirty of the Public

Health law, as alleged in the facts of the following:

1. Paragraphs A and A.1.
2. Paragraph A and A.2.
3. Paragraphs A and A.3. and A.3.a, b, c, d, e, f, g, h and/or i

FOURTH THROUGH SIXTH 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 alleged in the facts of the following:

4. Paragraphs B and B.2-5.
5. Paragraph H
6. Paragraph I and I 3

SEVENTH THROUGH NINTH SPECIFICATION

WILLFUL PATIENT ABUSE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(31) by willfully harassing or abusing a patient either physically or verbally, as alleged in the facts of:

7. Paragraphs B and B.2-5.
8. Paragraph H

9. Paragraph I and I 4

TENTH 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 alleged in the facts of:

10. Paragraphs C and any of its subparagraphs, D and any of its subparagraphs, E and any of its subparagraphs, F and any of its subparagraphs, G and any of its subparagraphs, I and any of its subparagraphs, J and any of its subparagraphs and K.

ELEVENTH 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 than one occasion as alleged in the facts of:

11. Paragraphs C and any of its subparagraphs, D and any of its subparagraphs, E and any of its subparagraphs, F and any of its subparagraphs, G and any of its subparagraphs, I and any of its subparagraphs, J and any of its subparagraphs and K.

TENTH AND ELEVENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

12. Paragraph A. and A.1
13. Paragraph B and B.4. and or B5

FOURTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

14. Paragraphs C and any of its subparagraphs, D and any of its subparagraphs, E and any of its subparagraphs, F and any of its subparagraphs, G and any of its subparagraphs and/or I and any of its subparagraphs.

FIFTEENTH SPECIFICATION

INFECTION CONTROL PRACTICES

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(47) by failing to use scientifically accepted infection control practices as established by the department of health pursuant to section two hundred thirty-a of the public health law as alleged in the facts of:

15. Paragraph J and any of its subparagraphs.

DATE: January 16, 2017
New Rochelle, New York


Roy Nemerson, Deputy Counsel
Bureau of Professional Medical Conduct