NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 9, 2017

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gerard A. Cabrera, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct

Craig Alan Schaum, Esq.
Schaum Law Offices
600 Old Country Road, Suite 320
Garden City, New York 11530

Nasim Haider, M.D.
[redacted]

Nasim Haider, M.D.
[redacted]

Nasim Haider, M.D.
Corona Medical Care
111-21 Roosevelt Avenue
Corona, New York 11368

RE: In the Matter of Nasim Haider

Dear Parties:

Enclosed please find the Determination and Order (No. 17-225) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:
Enclosure

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

----------X

IN THE MATTER OF NASIM HAIDER, M.D.

DETERMINATION AND ORDER

17-225

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A Notice of Hearing and Second Amended Statement of Charges, were served upon **NASIM HAIDER, M.D.** ("Respondent"). Pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("PHL"), **STEVEN M. LAPIDUS, M.D.**, Chairperson, **DEBORAH WHITFIELD, MA, PhD** and **DIANNE SIXSMITH, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee ("Committee") in this matter. **KIMBERLY A. O'BRIEN**, served as the Administrative Law Judge.

The Department of Health, Office of Professional Medical Conduct ("Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by **JEAN BRESLER,** Associate Counsel, and **GERARD CABRERA**, Associate Counsel.[1] The Respondent was represented by **CRAIG SCHAUM,** Esq. Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order, unanimously sustaining thirteen specifications of professional misconduct. After full consideration of the penalties available, the Hearing Committee has determined that to protect the people of the State of New York the Respondent's license to practice medicine shall be revoked.

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[1] Upon the pending retirement of Ms. Bresler, Gerard Cabrera, Associate Counsel, assumed post-hearing management of this matter.

PROCEDURAL HISTORY

Pre-Hearing Conference:	February 28, 2017
Hearing Dates:	March 1, 2017 March 29, 2017 April 27, 2017 May 4, 2017
Witnesses for Petitioner:	Anette Palk Patient H Patient A Robert Fuentes, MD
Witnesses for Respondent:	[redacted] Nasim Haider, MD
Written Submissions:	May 30, 2017
Deliberations Held:	June 8, 2017

STATEMENT OF CASE

The Department charged the Respondent with seventeen specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York, including the following: § 6530(2) – Practicing medicine fraudulently; § 6530(3) – Practicing medicine with negligence on more than one occasion; § 6530(5) – Practicing medicine with incompetence on more than one occasion or with a lack of knowledge necessary to practice the profession; § 6530(20) – Engaging in conduct in the practice of medicine that evidences moral unfitness; § 6530(21) – Willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department; §

6530(29) – Violating any term of probation or condition or limitation imposed on the licensee pursuant to § 230 of the Public Health law; § 6530(31) – Willfully harassing or abusing a patient either physically or verbally; § 6530(32) – Failing to maintain an adequate medical record; and § 6530(47) – Failing to use accepted infection control practices pursuant to § 230-a of the Public Health law. [2] The Respondent denies all the alleged specifications of professional misconduct. A copy of the Second Amended Statement of Charges is attached to this Determination and Order as Appendix A. [3]

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Numbers below in parentheses refer to exhibits ("Ex.") or transcript page numbers ("T."). The Hearing Committee hereby makes the following findings of fact:

1. The Respondent was authorized to practice medicine in New York State on December 6, 1994, by the issuance of license number 197993 [Ex.1; Ex.23].

2. At all relevant times, Respondent treated patients at Corona Medical Care, his private medical practice in Corona, New York ("Respondent's office") [Ex. 1].

Board of Professional Medical Conduct Order No. 04-285

3. In 2004, Respondent was charged with serious allegations of sexual misconduct and fraud [Ex.2 at p. 9-12].

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2 The General Counsel of the Department of Health has prepared a memorandum of law, "*Definitions of Professional Misconduct under the New York State Education Law*", on the definitions of professional misconduct set forth in New York Education Law, Section 6530 for the guidance of the hearing committees and the Administrative Law Judge [ALJ Ex. 2]. The Hearing Committee in reaching its determination used the definitions of misconduct provided in § 6530 and the explanations contained in the memorandum [Tr. 4].

3 On April 27th, the Department withdrew Factual Allegation I (3), and Specification 7 & 10 [Ex. 1].

4. OPMC met with Respondent and his Counsel to discuss the terms and conditions of the Order in detail; specific attention was given to the permanent license limitation/ chaperone requirements ("meeting") [Ex. 2, Ex. 3a; Tr. 26-34, 36].

5. At the end of the meeting, Respondent signed an "In-Person Interview Declaration," acknowledging that he understands and agrees to the terms of the Order, and that to continue to practice medicine in New York State he is required to comply and that he is in current compliance with the terms of the Order [Ex. 2, Ex. 3a, Ex. 3b; Tr. 32-37].

6. Respondent is subject to Board of Professional Medical Conduct Order No. 04-285 ("Order"), effective date December 20, 2004. The Board among other things imposed a $10,000.00 monetary fine, a thirty-six-month suspension with a four-month actual suspension, three-year probation, and a permanent license limitation that requires Respondent to consult and treat all female patients in the presence of a chaperone who has been vetted and approved by the Office of Professional Medical Conduct ("OPMC") [Ex. 2].

Permanent License Limitation/Chaperone Requirements

7. The Order contains a permanent license limitation that is in effect if Respondent practices medicine in New York State. Respondent must consult and treat all female patients in the presence of a chaperone who has been vetted and approved by the Office of Professional Medical Conduct ("OPMC") [Ex. 2, Ex. 4; Tr. 26-27, 40-44].

8. Respondent is required to propose to OPMC chaperones that are licensed or registered health care professionals. Once the chaperone is vetted and approved by OPMC, the chaperone must submit to an OPMC interview and sign a "Third Party Chaperone Acknowledgement" acknowledging that the chaperone read the Respondent's Order and understands the duties and responsibilities of a chaperone ("chaperone requirements") [Ex. 2, Ex. 4, Ex. 9, Ex. 26; Tr. 26-27, 40-45, 122].

9. The Order defines the duties and responsibilities of a chaperone including that the chaperone must be present for the entirety of Respondent's encounter with the patient; personally sign the patient chart/ medical record; maintain and exclusively control a chaperone log; submit quarterly chaperone reports and produce the chaperone logs for inspection; and immediately report to OPMC any violation of the order or inappropriate behavior ("chaperone requirements") [Ex. 2, Ex. 3a, Ex. 3b, Ex. 9, Ex.28; Tr. 31-37, 40-47, 124-126, 128-130].

10. In 2005, Respondent proposed four chaperones to OPMC; but only one of the proposed chaperones was a licensed or certified health care worker. On May 16, 2005, OPMC approved the only qualified chaperone proposed by Respondent ("approved chaperone") [Ex. 9, Ex. 26; Tr. 31, 37-41].

11. In 2006, the approved chaperone left Respondent's employment. Respondent did not propose or seek OPMC approval of another chaperone [Ex. 9, Ex. 26; Tr. 31, 37-41, 83, 539].

12. From approximately 2006 through September 2015, Respondent employed "chaperones" who were not vetted and approved by OPMC including [redacted] January 2009 through August 2011, and [redacted] August 23, 2011 through September 12, 2015 ("unapproved chaperones") [Ex. 28; Tr. 40-43, 456, 468-469, 521].

13. Respondent did not make the unapproved chaperones aware of the Order and its terms, or the allegations against Respondent that led to the permanent license limitation/ chaperone requirements [Tr. 79, 454-459, 468-470].

14. The unapproved chaperones did not sign each patient chart after each patient visit and they were not with Respondent for the entire patient encounter; it was Respondent who called for them [Ex. 10-18, Ex. 26, Ex. 28, Ex. 30; Tr. 83-89, 441, 450-452, 456, 464-469, 484, 510, 514, 518, 521, 525-526, 539, 585].

15. In several instances, patient visits appear in the chaperone logs, but no corresponding visit appears in the patient medical record, and vice versa. Respondent saw patients without a chaperone [Tr. 79, 83, 145, 150, 458-459, 464-465, 518; Ex. 28, Ex. 30].

Respondent's March 8, 2012 arrest by the New York City Police Department

16. On February 27, 2012, Patient H, a young unemployed woman who only speaks Spanish, went to Respondent's office to obtain an immigration physical. While unchaperoned, Respondent examined Patient H, and he offered her an evening job cleaning his office ("job") [Tr. 142-143, 145: Ex. 8].

17. On the evening of March 2, 2012, Patient H's second day on the job, she was alone with Respondent in his office. Respondent told her to stop working and sit with him in a room where he was watching television. While she was watching television, he grabbed her hand and placed it on his exposed penis. He told her to massage his penis. Patient H got up to leave, and Respondent grabbed her buttocks and breasts and attempted to kiss her. Patient H broke free from Respondent and left the office. Patient H went directly to the police station and made a report [Tr. 152-155; Ex. 8].

18. A short time after leaving the police station, Patient H asked her husband to take her to the hospital where she could be "safe" [Tr. 157]. While in the hospital, Patient H consistently reported to her physicians that she felt very fearful, anxious and scared after being sexually assaulted by Respondent. Patient H consistently reported that Respondent forced her to touch his penis and without her consent he touched her breasts and buttocks [Tr. 157-159; Ex. 8, Ex. 20 at p. 11 &15].

19. Patient H continued to cooperate with the police. She went back to the police station when asked, and twice she spoke to the police on the phone [Tr.159-160, 163].

20. On or about March 8, 2012, Respondent was arrested by the New York City Police Department and charged with sexual abuse and forcible touching [Ex. 7; Tr. 22-24, 46].

21. On or about October 7, 2012, Respondent signed and submitted to OPMC a Compliance Declaration, wherein Respondent falsely declared that he was in compliance with the Order and that he had "not been arrested, charged, or convicted in any criminal or civil matter" [Ex. 5, Ex. 7; Tr. 24-25, 48-50, 601-602].

22. On or about May 2013, OPMC became aware that Respondent had been arrested and charged on March 8, 2012 and it began an investigation [Ex. 7; Tr. 22-24, 46].

23. On or about November 12, 2013, Respondent submitted a Data Sheet to OPMC, wherein Respondent falsely answered "No" to the question "Since the effective date of your order, have you been arrested, charged, or convicted in any criminal or civil matter?" [Ex 6; Tr. 108-109].

November 13, 2013 Unannounced Visit to Respondent's Office by OPMC Investigators

24. On November 13, 2013, at approximately 11:45am, OPMC Investigators, Anette Palk and April Soltren ("investigators"), made an unannounced visit to Respondent's office ("site visit"). The investigators observed the conditions in Respondents office, took pictures, and requested medical records and chaperone logs [Ex. 21 A-W, Ex. 26; Tr. 50-53, 56-60].

25. Unapproved chaperone, [redacted] who appeared during the site visit at approximately 3:00pm, testified that during the period, 2011-2015, she was the only "chaperone" employed by Respondent and that he kept current chaperone logs in his possession [Tr. 514].

26. On the morning of the site visit, Respondent had seen two female patients without a chaperone. The investigators requested all Respondent's chaperone logs including the log with the entries for that day, November 13, 2013. Respondent could not produce the chaperone log entries for that day, or the chaperones logs for the year 2013 or 2012 [Tr. 56-60, 73-74, 90-91].

27. Physicians are required to use scientifically accepted techniques for injury prevention and engineering controls to reduce the opportunity for infection through contact with used sharps. Used sharps

are contaminated with bodily fluids and must be disposed of in a specially engineered "closed container" [Tr. 373-374; 10 NYCRR 92-2.1(b)].

28. On a desk in a room in Respondent's office where blood is drawn ("blood draw room"), there was an open jar labeled "*MARIAN ALL NATURAL STICK CINNAMON*" ("spice jar") and it was filled with used "lancets" ("sharps"); and on the floor in front of the hand washing sink, Respondent stored used sharps in an open plastic pail ("open pail") [Ex. 21-L, M, O, P; Tr. 69-70, 374-375].

29. Physicians are required to use scientifically recognized standards for handwashing [Tr. 381; 10 NYCRR 92-2.1(a)].

30. The hand washing sink in Respondent's blood draw room was "dry" and surrounded by clutter, and the towel dispenser was empty. An open pail containing used patient sharps and a garbage pail were in front of the hand washing sink; rendering the sink unusable for Respondent and his staff to wash their hands between patients [Tr. 69-70; 380-382; Ex. 21 F, L, J, K, O, P; Tr. 381-382].

31. To maintain the efficacy of vaccines and the integrity of blood samples they must be kept at a temperature between 35 - 44 degrees Fahrenheit [Tr. 385-386].

32. Respondent stored vaccines (flu, tetanus and diphtheria) and a patient blood sample in a refrigerator without a device to monitor temperature [Tr. 70-71].

Respondent's Patient Care

33. At each patient visit a physician is required to obtain and record vital signs, blood pressure, temperature and pulse; obtain and record appropriate history; conduct an appropriate physical examination and record findings; and order appropriate lab work/tests and record findings/ results ("information"). A physician must consider this information when developing a diagnosis, treatment plan and prescribing medications [Tr. 213-217].

34. Before prescribing medication to a female patient of child bearing age that is contraindicated during pregnancy, a physician must obtain and record menstrual history and pregnancy status [Tr. 216, 240].

35. Respondent repeatedly prescribed medications that are contraindicated during pregnancy to his female patients of child bearing years without obtaining menstrual history and pregnancy status [Tr. 207-212, 254, 274-275].

36. If a patient has an elevated temperature, it may indicate the presence of a bacterial infection, which may appropriately be treated with antibiotics [Tr. 214, 240-241, 247].

37. When a patient presents with a complaint of breast, vaginal, pelvic or rectal symptoms/pain, a physician should, among other things, conduct and record the findings of a focused physical examination of that part of the body [Tr. 216, 234, 251, 254-256, 270-273].

38. When a patient presents with a complaint of a rash, a physician should, among other things, obtain and record the patient's temperature, history related to the rash and allergies; and conduct and record the findings of a focused physical examination including location, appearance, and size of the rash [Tr. 234, 241-242,253-254, 274].

39. Respondent does not have his patients disrobe, he performs physical examinations over patients' clothes. Respondent repeatedly treated and prescribed medications for his patients who presented with complaints of a rash, and or symptoms/pain related to the breast, vagina, pelvis, or rectum; he did not conduct or record findings of a focused physical examination [Tr. 99, 102, 270 -272; 526-528, 532-533, 584-586, 588-589, 618, 620].

40. **Patient C** was a 23-year-old woman who emigrated from Mexico. During Patient C's initial visit, Respondent did not obtain or document information regarding Patient C's past medical history,

social history, family history, medication history, immunization history, and menstrual/pregnancy history. No vital signs were recorded and the physical examination section on the patient's medical record was left blank [Ex. 12a, Ex.12b; Tr. 207-212, 214].

41. Patient C's initial presenting complaint was epigastric pain. Respondent failed to obtain information about her diet; whether the pain was isolated or recurrent; whether she experienced weight loss; or whether she had taken any over the counter medications and, if so, whether she experienced any relief from these medications [Ex. 12b; Tr. 208, 211].

42. Patient C had a history of hepatitis, but Respondent did not determine whether Patient C had been vaccinated for Hepatitis B [Ex.12a, Ex.12b, Ex. 12c; Tr. 100-101].

43. Respondent ordered lab work; the test results indicated that Patient C had elevated liver enzymes and elevated H-Pylori titer, but Respondent did not ensure that Patient C received follow up care [Tr. 215-219, 556-557].

44. **Patient D** is a woman of child bearing age, who Respondent treated from 2009-2013. At the initial visit, Respondent failed to obtain a complete medical history, family history, social history, and menstrual/pregnancy history. Respondent also failed to provide a physical examination for Patient D or obtain a full set of vital signs [Ex. 13b at p. 2-7; Tr. 233-234].

45. On five separate visits, Respondent failed to record any vital signs for Patient D [Ex. 13b; Tr. 214].

46. On three separate visits, Patient D presented with a complaint of headaches. Respondent failed to obtain a basic history related to the headaches including frequency and duration; and inquire about whether she had experienced sinus pain, change of vision, and or nausea [Ex.13a, Ex. 13b; Tr. 235-236].

47. Respondent ordered a CT of Patient D's head. The CT scan showed sinusitis, but Respondent failed to follow-up by examining Patient D's sinuses [Ex. 13a, Ex. 13b; Tr. 236-237].

48. On two occasions, Patient D presented with complaints of dysuria and frequency of urination; Respondent failed to obtain a history, vital signs, urine samples, or order laboratory cultures. Respondent prescribed ciprofloxacin without obtaining menstrual history or pregnancy status; ciprofloxacin is contraindicated during pregnancy [Ex. 13a, Ex. 13b; Tr. 102, 239-241].

49. Patient D presented with a rash; Respondent failed to obtain a sufficient history or perform a physical examination to determine the cause of the rash. Respondent prescribed minocycline without obtaining menstrual history or pregnancy status; minocycline is contraindicated during pregnancy [Ex. 13b; Tr.241-242].

50. On June 13, 2012, Patient D presented with a complaint of kidney stones and allergic reaction to antibiotics that were prescribed to her on a recent visit to the emergency room. Respondent failed to obtain vital signs, obtain any history related to the diagnosis of kidney stones, and he did not perform a physical examination. Respondent also failed to obtain a history of the reported allergic reaction and failed to examine Patient D for evidence of an allergic reaction [Ex. 13b; Tr. 244-247, 260-262].

51. On June 20 2012, Patient D presented with a complaint of back pain. Respondent failed to obtain a history and conduct a physical examination, and did not consider whether the complaint of back pain was related to the kidney problems she reported a week earlier and refer her to a urologist. Respondent failed to obtain and or record Patient D's temperature and prescribed ciprofloxacin without determining pregnancy status; ciprofloxacin is contraindicated during pregnancy [Ex. 13a, Ex.13b; Tr. 149, 240-242, 247-248, 260-262].

52. On June 27, 2013, Respondent treated Patient D for a vaginal fungal infection without performing a vaginal exam, pelvic exam and obtaining a culture to rule out other causes of vaginal discomfort and discharge [Ex. 13b; Tr. 250-252, 533].

53. Patient D presented with a complaint of breast pain and Respondent failed to conduct a focused breast examination including the axilla [Ex. 13a at p.8; Tr. 255, 532-533].

54. Patient D presented with a rash on both the right and left leg. Respondent failed to obtain a history, record a description of the rash, or obtain the patient's temperature. Respondent prescribed oral prednisone without considering the efficacy of topical medications and without obtaining menstrual history or pregnancy status; oral prednisone is contraindicated during pregnancy [Ex. 13b, P.7; Tr.254].

55. On April 26, 2011, Patient D presented with a complaint that she had not had a period in four months. Respondent's encounter with Patient D was unchaperoned. Respondent diagnosed uterine fibroids without ordering a pregnancy test [Ex. 13b at p. 4; Tr. 263-264].

Patient E

56. **Patient E** is a woman of child bearing age, who Respondent treated from August 2010 - 2015. While Patient E was under his care, Respondent failed to obtain a patient history including medical history; past surgical history; family history; social history; menstrual /pregnancy history; and immunization history [Ex.14b at p. 3-5; Tr. 267].

57. On November 27, 2012 Patient E presented with a complaint of rectal bleeding and constipation. Respondent diagnosed hemorrhoids without obtaining a history related to her symptoms, conducting a physical examination of the abdomen including checking for masses and tenderness, and or a rectal examination [Ex. 13b at p. 3; Tr. 269-270, 586].

58. On October 5, 2013, Patient E again presented with a compliant of rectal bleeding. Once again Respondent diagnosed hemorrhoids without obtaining a history related to her symptoms; and

conducting a physical examination of the abdomen including checking for masses and tenderness and rectal examination [Ex. 14c at p.2; Tr. 273].

59. On February 23, 2013 and on August 19, 2013, Patient E presented with a complaint of a rash. Respondent prescribed oral minocycline without obtaining a menstrual history or pregnancy status; minocycline is contraindicated during pregnancy. [Ex.14b at p. 4-5; Tr. 275 -276].

60. On November 5, 2015, Patient E presented with a complaint of vaginal discharge. Respondent prescribed two anti-fungal agents without first performing a vaginal and pelvic examination, or obtaining a culture [Ex. 14c at p.2; Tr. 99, 250-251, 279].

61. **Patient F** is a female. At the initial visit, Respondent failed to obtain and or record any vital signs other than blood pressure, and obtain and record a detailed patient history [Ex.15b at p.1; Tr. 214, 284-288].

62. Patient F presented with a complaint of epigastric pain. Respondent failed to obtain history of similar symptoms/ episodes and family history; obtain sufficient relevant information about Patient F's diet; or ask whether Patient F had been in contact with people with similar symptoms, [Tr. 290-291; Ex.15b at p.1].

63. Patient F presented with complaint of vaginal discharge. Respondent prescribed medication without performing a vaginal and pelvic examination, and obtaining a culture [Tr. 250-251, 292; Ex. 15b at p.2].

64. Respondent treated Patient F's open surgical incision without obtaining vital signs, and without adequately documenting a description of the incision. Respondent failed to contact the surgeon who performed the surgery or failed to record the contact he had with the surgeon [Tr. 293-295; Ex. 15b at p.3].

65. On May 5, 2011, Patient F presented with a complaint of cough and sore throat. Respondent prescribed antibiotics without obtaining Patient F's temperature (high temperature would indicate presence of infection); obtaining and recording a description of chest sounds including crackling or wheezing; or recording pertinent negatives such as no abnormal sounds or no rhonchi [Tr. 99-100, 296-297, 314; Ex. 15b at p. 4]

66. On May 26, 2013, Patient F presented with a swelling of the neck and jaw. Respondent did not examine her neck, jaw, mouth, sinuses, thyroid and lymph nodes, or obtain her temperature [Tr. 299-301, 310-311, 317; Ex. 15b at p.4].

67. On May, 11, 2011 and May 26, 2013, Respondent treated Patient F without the presence of a chaperone [Ex. 15b].

68. **Patient G** is a 73-year-old woman. At the initial visit, Respondent failed to obtain a full set of vital signs; conduct a full physical examination; conduct a neurological examination; and conduct a mental status examination. Additionally, Respondent failed to obtain and record any family history, and a detailed medical history [Tr. 322-324, 327-331; Ex.16b at p. 3 & 40].

69. On many visits, Respondent failed to obtain and or record vital signs [Tr. 214].

70. On December 15, 2012, Patient G presented with a complaint of epigastric discomfort. Respondent failed to conduct a physical exam, obtain a history of the symptoms, or evaluate the cause of the epigastric discomfort [Tr. 338-339; Ex. 16b at p.6].

71. On July 17, 2013, Patient G presented with a complaint of a cough. Respondent ordered a chest x-ray and prescribed cough medicine without examining Patient G's throat or chest [Tr. 346; Ex. 16 at p. 9].

72. The chest x-ray revealed that Patient G had a mildly enlarged heart. Respondent failed to record these findings in the medical record or ensure that Patient G followed up with a cardiologist [Tr. 347-349, Ex.16b at p. 47].

73. **Patient I** is a woman of childbearing years. On October 13, 2013, her initial visit, Patient I presented with a complaint of vaginal discharge. Respondent failed to obtain vital signs, obtain a full history, conduct a vaginal and pelvic examination, or order a vaginal culture [Ex. 18a at p. 2-3; Tr. 207-209,214, 284-287, 354-356].

74. On June 6, 2014, Patient I presented with a complaint of a sore throat. Respondent prescribed Zithromax without obtaining and recording Patient I's temperature or any other vital signs [Tr. 350-351, 356; Ex. 18b at p. 2-3].

75. On June, 22, 2014, Patient I presented with a complaint of vaginal discharge. Respondent did not perform a vaginal and pelvic examination, and order a vaginal culture [Tr. 99, 355-356, 18a at p. 3].

DISCUSSION & CONCLUSIONS

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (*See* Prince, Richardson on Evidence § 3-206). The Committee unanimously sustained thirteen concluded specifications of misconduct.

Specifications 1-4 Violating Terms of the Order

The Department alleged in its first through fourth specifications of misconduct that Respondent is guilty of violating any term of probation or condition or limitation imposed on the licensee pursuant to §

230 of the Public Health Law. The Department specifically alleged its first and fourth specifications of misconduct that Respondent failed to report that he had been arrested and charged or convicted in any criminal or civil matter; and it alleged in the second and third specifications of misconduct that Respondent falsely affirmed that he was in compliance with the Order including the chaperone requirements contained in the Order

Ms. Palk, OPMC Investigator, provided credible testimony about the Order, Respondent's responsibilities under the Order and OPMC's investigation of Respondent. Before entering into the Order, Respondent and his then counsel, met with OPMC and reviewed the terms of the Order including the permanent license limitation and the chaperone requirements. Respondent agreed to its terms and signed the Order.

Ms. Palk testified that in April of 2013, OPMC received a routine report from the National Practitioners Databank. The report revealed that on March 8, 2012 Respondent had been arrested and charged in a criminal matter. All physicians who are subject to an Order must periodically complete and submit both a Compliance Declaration and a Data Sheet to update their information. The Compliance Declaration and Data Sheet ask a physician to report if he has "been arrested, charged, or convicted in any criminal or civil matter." On two occasions, October 2012 and November 2013, Respondent falsely reported that he had not been arrested or charged in a criminal or civil matter.

Under the terms of the Order, Respondent had a permanent license limitation requiring him to adhere to the chaperone requirements contained in the Order including that a chaperone(vetted and approved by OPMC) must be present for the entirety of Respondent's encounter with any female patient; the chaperone must personally sign the patient chart/ medical record; the chaperone must maintain and exclusively control the chaperone log; the chaperone must submit quarterly chaperone reports and produces the chaperone logs for inspection; and the chaperone must immediately report to OPMC any

violation of the order or inappropriate behavior ("chaperone requirements"). Shortly after entering into the Order, Respondent proposed four potential chaperones to be vetted and approved by OPMC, and only one chaperone was approved by OPMC. Within about a year from when OPMC approved the chaperone, she left Respondent's employ and Respondent never proposed any other potential chaperones to be vetted and approved by OPMC.

The OPMC investigation revealed that Respondent hired his own unapproved chaperones and he did not make them aware of the Order, the allegations that lead to the Order and the chaperone requirements. Respondent's patients, and his medical records and chaperone logs reveal that in many instances no chaperone was present during the patient encounter. Ms. Palk testified that on the morning of the November 13, 2013 site visit, Respondent had seen two female patients, but could not produce log entries for that day, or the chaperone logs for 2012 or 2013.

Unapproved Chaperones

The unapproved chaperones testified at the hearing; they appeared to be very supportive of Respondent. They each testified that they knew nothing about the Order, the chaperone requirements contained in the Order or the allegations against Respondent that lead to the Order and the permanent license limitation/chaperone requirements. The unapproved chaperones told the Committee that at each patient visit, Respondent called them to come to the examination room. While both unapproved chaperones maintained chaperone logs containing entries with the patient name, date and time of the visit followed by their signature, Respondent had access to and control of the chaperone logs.

Respondent

Respondent admitted that on March 8, 2012 he was arrested for allegedly abusing Patient H and that he was charged [Tr. 604]. Respondent also admitted that on or about October 2012 he submitted a Compliance Declaration to OPMC wherein he affirmed that he had not been arrested or charged with a

crime and that he was in compliance with the terms of the Order. Respondent told the Hearing Committee that the reason he did not report the fact that he was arrested and charged with a crime was because there was "no case" [Tr. 540-541]. But the charges were not dismissed until April 10, 2013, six months after Respondent submitted the Compliance Declaration [Tr. 602-603; Ex. N]. On or about November 12, 2013, Respondent signed and submitted a Data Sheet to OPMC wherein he did not report the March 8th arrest and charges. Once again Respondent told the Hearing Committee that the reason he did not report the March 8th arrest and charges to OPMC was because the charges had been dismissed; his criminal defense lawyer told him he did not need to report it [Tr. 600-601].

The Committee

Upon his own admission, Respondent knew full well that on March 8th he was both arrested and charged with crimes. The inquiries on both the Compliance Declaration and the Data Sheet asked Respondent to report arrest(s) as well as criminal or civil charges brought against him. Regardless of when the charges were dismissed, it had no bearing on Respondent's responsibility to report the March 8th arrest and charges to OPMC. The Committee found that Respondent intentionally failed to disclose the arrest and the charges on both the Compliance Declaration and the Data Sheet. Accordingly, the Hearing Committee sustained the first and fourth specifications of misconduct. Specifications 1 & 4

Sustained

Initially Respondent proposed chaperones to OPMC, and one chaperone was approved. But after the approved chaperone left Respondent's employ, he failed to propose any other chaperones to OPMC. While the Committee understood why the Department attempted to put the unapproved chaperones on trial, the Committee believed that the unapproved chaperones were merely following the directions of Respondent, their employer. The testimony of the unapproved chaperones revealed that Respondent did not inform them about the Order, the reasons contained therein for the permanent license limitation, and

chaperone requirements; and Respondent did not have them chaperone the entire patient encounter and he maintained control over the chaperone logs. The Committee found that Respondent willfully and repeatedly violated the chaperone requirements contained in the Order. Accordingly, the Hearing Committee sustained the second and third specifications of misconduct. Specifications 2 & 3 *Sustained*

Specifications 5 & 6 (7 *Withdrawn*) Moral Unfitness in the Practice of Medicine

The Department alleged in its fifth and sixth specifications of misconduct that Respondent is guilty of engaging in conduct in the practice of medicine that evidences moral unfitness.

Ms. Palk testified that she and another OPMC investigator, April Soltren, made an unannounced visit to Respondent's office on November 13, 2013. The investigators encountered Patient A just outside Respondent's office. Patient A told the investigators that she was a patient of Respondent's and had just been examined by Respondent for an immigration physical. When Patient A was asked by the investigators whether there was a chaperone in the room when she was examined by Respondent, Patient A said "Yes". Subsequently, Patient A told OPMC that a chaperone was not present during the November 13th exam; that Respondent inappropriately touched her by rubbing her "Abdomen, groin, hips/and or buttocks" ("alleged incident"); that Respondent falsely advised her that she required a "pelvic sonogram" that he would provide; and that Respondent offered her a job. At the hearing, Patient A testified that after the alleged incident she returned to Respondent's office to follow-up on the Respondent's job offer; and that her "lawyer" sent Respondent a letter to advise him that she was going to "sue" him, but she did not follow through with the suit.

The Committee found Patient A's account of the alleged incident was both inconsistent and unconvincing. First, she told the investigators that there was a chaperone present during the exam. Later she told them that there was not a chaperone present during the exam and that Respondent abused her. The Committee believes that if the alleged incident had occurred, Patient A would have immediately

reported it to the investigators she encountered outside Respondent's office just moments after the incident; and at some point she would have reported the incident to the police. Patient A's credibility was further eroded in the eyes of the Committee in that she provided inconsistent reports to the investigators; that she returned to Respondent's office after the alleged incident; that she had her attorney send a "preliminary" letter to Respondent threatening to sue him over the alleged incident, but she never did sue him; and that her testimony was inconsistent and her answers to questions were evasive.

Based on the foregoing, the Committee did not credit Patient A's account of the alleged incident. Other than Patient A's account of the alleged incident, the Department offered little else to substantiate the allegation. Accordingly, the Committee did not sustain the fifth specification of misconduct. Specification 5 *Not Sustained.*

Patient H

At the hearing, Patient H provided credible, consistent and compelling testimony about the incident. On February 27, 2012, Patient H who was newly married, went to Respondent's office to get an immigration physical ("immigration exam"). She chose to go to Respondent for the immigration exam because he had the "cheapest price" [Tr. 157]. Patient H speaks only Spanish, and at the time of the unchaperoned immigration exam she shared with the Respondent that she did not have a job. During the immigration exam, Respondent offered Patient H a job cleaning his office. She was so "happy" to have a job and she purchased a uniform [Tr.161]. On the evening of March 2, 2012, just a few days after the immigration exam, Patient H reported to "work" at Respondent's office and was sexually abused by Respondent. After Patient H freed herself from Respondent, she left Respondent's office and went directly to the police station and reported the incident. A few hours after she reported the incident, she asked her husband to take her to the hospital because she wanted to feel "safe" [Tr.157]. After she was released from

the hospital, she went to counseling; but she stopped going because every time she had to "retell the story"; she never returned to Respondent's office and will not go near his office [Tr. 157-167].

Respondent

Respondent denied the charges, but he did not deny that he had a physician patient relationship with Patient H or that he had conducted an immigration exam or that he offered Patient H a "job" based on the information she provided to him at the immigration exam. Respondent told the Committee that Patient H made up the charges of abuse because he fired her "right there" when he saw that she was cleaning with a product that was ruining the paint on the walls [Tr. 599-602].

The Committee

The Committee found that Patient H, a newly married immigrant who only speaks Spanish and is unemployed, would not go to the police to make false accusations of sexual abuse against a powerful member of the community; a physician. The Hearing Committee found that Respondent clearly saw how vulnerable Patient H was, and that he used the information he obtained about Patient H during the unchaperoned immigration exam to lure her to his office on the evening of March 2nd, and that he abused her in his medical office. Accordingly, the Hearing Committee sustained the sixth specification of misconduct. Specification 6 -- *Sustained*

Specifications 8 & 9 (*10 Withdrawn*) Willful Patient Abuse

The Department alleged in its eighth specification of misconduct that Respondent willfully harassed or abused a patient either physically or verbally. The Hearing Committee concluded that Patient A's account of the alleged incident of abuse by Respondent was not credible [See Discussion & Conclusions - Specification 5 Moral Unfitness in the Practice of Medicine]. Accordingly, the Hearing Committee did not sustain the eighth specification of misconduct. Specification 8 - *Not Sustained*

The Department also alleged in its ninth specification of misconduct that Respondent willfully harassed or abused a patient either physically or verbally. The Hearing Committee concluded that Patient H's account of the incident of abuse by Respondent was extremely credible [See Discussion & Conclusions - Specification 6 Moral Unfitness in the Practice of Medicine]. Accordingly, the Hearing Committee sustained the ninth specification of misconduct. Specification 9 *Sustained*

Specification 11 Negligence on More Than One Occasion

The Department alleged in its eleventh specification of misconduct that Respondent practiced medicine with negligence on more than one occasion in the care and treatment of his patients. The Department was required to show that on more than one occasion Respondent failed to "exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. It involves a deviation from acceptable medical standards in the treatment of a patient" [ALJ Ex. 2].

Dr. Fuentes

The Department's expert witness, Robert Fuentes, M.D., is a Board-Certified Internist with many years of experience treating adults in a private practice setting. The Hearing Committee found Dr. Fuentes had the appropriate training and experience to testify about whether the care and treatment Respondent provided to his patients met acceptable standards of care. Dr. Fuentes testified that at each patient visit a physician is required to obtain and record appropriate patient histories and vital signs, conduct a focused physical examination and record findings; and order appropriate lab work/tests and obtain and consider results. He emphasized that vital signs are an essential part of any physical examination that is why they are called "vital" [Tr. 214]. Patient vital signs assist a physician with assessing a patient's general physical condition, and with diagnosing and treating a medical problem. A physician must record accurate and complete patient information so that the physician can see the patient's complete health picture and that continuity of care can be provided by subsequent treating physicians. If accurate and

complete information is not documented in the patient medical record at each patient encounter, the information is lost forever [Tr. 265, 284].

When prescribing medication, a physician is required to take the necessary steps to evaluate whether it is medically necessary and whether there are other medications that would be safer and/or more effective. Before prescribing antibiotics to a patient, a physician must, among other things, confirm whether that patient has a fever; a fever along with other symptoms indicate a possible bacterial infection. If the patient does not have a fever, a physician must consider whether antibiotics would be effective. Unnecessary exposure to antibiotics can complicate the patient's condition, including exposing the patient to allergic reaction, distortion of intestinal bacteria that can lead to super infection [Tr. 297]. Before prescribing medications to a female patient of child bearing age, a physician must confirm, among other things, menstrual history and pregnancy status [Tr. 209].

Dr. Fuentes testified that Respondent's own medical records show that Respondent regularly diagnosed, treated and wrote prescriptions for his patients without obtaining and recording appropriate histories and vital signs, conducting and recording the results of a focused physical examination, and without ordering appropriate lab work/ tests and if ordered he did not record or consider the results. Respondent often failed to obtain and record a full set of vital signs at each patient visit and sometimes he failed to record any vital signs. Respondent repeatedly prescribed medications without assessing whether they were medically necessary including that Respondent repeatedly prescribed antibiotics to his patients without confirming whether that the patient had a fever; he repeatedly prescribed medications that are contraindicated during pregnancy to his female patients of child bearing years without obtaining menstrual history and pregnancy status; he repeatedly prescribed anti-fungal medication(s) to his female patients complaining of vaginal discharge, without obtaining a temperature or performing a vaginal and/or pelvic examination; and he repeatedly treated patients who presented

with complaints of a rash without examining the rash and recording a description of the size and location of the rash.

Dr. Fuentes testified that accepted infection control practices require a physician to store used sharps in a specially engineered container, which prevents the physician, employees and patients from coming in contact with and being infected by the used sharps; the handwashing sink must remain clutter free and accessible to a physician and his employees to wash hands between patients; and store vaccines and patient specimens at a temperature between 35-40 degrees Fahrenheit, to insure their integrity. The photos taken during the site visit show that Respondent failed to follow accepted infection control practices in that he stored used sharps in both an open spice container and an open pail on the floor in his office; the hand washing sink in the blood draw room was cluttered and inaccessible to Respondent and his employees; and Respondent stored vaccines and patient specimens in a refrigerator that had no thermometer to monitor temperature.

Respondent

Respondent testified that he was a Board Certified in Internal Medicine. Respondent told the Committee that he did not accept insurance, and he provided his services for a reasonable fee. He talked with his patients to obtain histories; and both he and his chaperones took vital signs for each patient at every visit, but if its "normal" he does not always record it in the medical record [Tr.629-630]. Respondent said that he performs physical examinations over his patients' clothes, and he does not perform breast, pelvic or rectal exams. But he treated and prescribed medications for female patients who complained of breast, vaginal, pelvic and rectal pain/ symptoms.

In defending his infection control practices, Respondent told the Committee that he hired a cleaning service that came regularly to clean his office. Respondent explained to the Committee that he is a diabetic and he must regularly check his blood sugar; the used "lancets"/ sharps that he kept in the

spice jar in the blood draw room were his own and there was no reason anyone else would come into contact with them [Tr. 608, 613] He also explained that he and his employees regularly got infection control training [Tr. 540].

Committee

The Committee concluded that Respondent could not be Board Certified in Internal Medicine if he lacked the requisite skill and training of a reasonably prudent physician. While Respondent was capable of meeting the standard of care, Respondent's own records and testimony show that he was negligent in the care and treatment he provided to his patients including that he repeatedly failed to obtain patient histories; obtain vital signs; perform physical examinations; review systems; order appropriate tests; follow up on abnormal test results; maintain and record required patient information in the medical records; and or obtain and consider necessary patient information before diagnosing, treating and prescribing medications. The testimony of Dr. Fuentes and Respondent himself show that Respondent did not follow accepted infection control practices including that Respondent failed to secure used sharps in appropriate containers; failed to maintain access to the hand washing sink; and failed to store vaccines and a patient specimen in a refrigerator where the temperature could be monitored. Accordingly, the Hearing Committee sustained the eleventh specification of misconduct. Specification 11 - *Sustained*

Specification 12 Incompetence in the Practice of Medicine

The Department alleged in its twelfth specification of misconduct that Respondent is guilty of incompetence in the practice of medicine [ALJ Ex. 2]. For the Committee to sustain a charge of incompetence, the Department would need to show that Respondent lacked the requisite skill, knowledge and training to practice. But in fact, the Committee determined that the reverse is true; Respondent possessed the requisite skill, knowledge and training to meet the standard of care, but failed to do so [See

Discussion & Conclusions - Specification 11 Negligence on More Than One Occasion]. Accordingly, the Committee did not sustain the twelfth specification of misconduct. Specification 12 - *Not Sustained*

Specification 13, 14 & 15 Fraudulent Practice

The Department alleged in its thirteenth and fourteenth specification of misconduct that Respondent is guilty of fraudulent practice, which includes "intentional misrepresentation or concealment of a known fact which is made with the intent to deceive" [ALJ Ex. 2]. The Department was required to show that Respondent knowingly and intentionally concealed the fact that he was arrested and charged on March 8th. The Hearing Committee concluded that Respondent was aware of the March 8th arrest and charges and Respondent chose not to declare it on both the Compliance Declaration and the Data Sheet he submitted to OPMC [See Discussion & Conclusions - Specification 1&4 Moral Unfitness in the Practice of Medicine]. Accordingly, the Committee sustained the thirteenth and fourteenth specifications of misconduct. Specification 13&14 - *Sustained*

In its fifteenth specification of misconduct, the Department also alleges that Respondent is guilty of fraudulent practice. While the Committee found that the Department showed that Respondent's medical record for Patient A ("medical record") is lacking and that Respondent provided the medical record in pieces and at different times, the Department failed to show that Respondent knowingly and willfully intended to deceive when he provided the medical record to OPMC or that he "falsely purported to have created (Patient A's) record on November 15, 2013" [Ex. 1]. Accordingly, the Hearing Committee did not sustain the fifteenth specification of misconduct. Specification 15 - *Not Sustained*

Specification 16 Failure to Maintain Patient Records

The Department alleged in its sixteenth specification of misconduct that Respondent is guilty of failing to maintain patient records. For the Committee to sustain the charge, the Department was required to show that Respondent failed to maintain records for each patient that "accurately reflect the evaluation

and treatment of the patient" [ALJ Ex. 2]. The Hearing Committee concluded that Respondent repeatedly failed to record patient histories, vital signs, physical examination findings, ordered lab work/ tests & results, and diagnoses [See Discussion & Conclusions – Specification 11 Negligence on More than One Occasion]. Accordingly, the Hearing Committee sustained the sixteenth specifications of misconduct. Specification 16 - *Sustained*

Specification 17 Infection Control Practices

The Department alleged in its seventeenth specification of misconduct that Respondent is guilty of failing to use scientifically accepted infection control practices as established by the Department of Health. The Hearing Committee found that Respondent failed to follow accepted infection control practices [See Discussion & Conclusions – Specification 11 Negligence on More than One Occasion]. Accordingly, the Committee sustained the seventeenth specification of misconduct. Specification 17 - *Sustained*

Specification 18 & 19 Filing a False Report

The Department alleged in its eighteenth and nineteenth specification of misconduct that Respondent is guilty of "willfully filing a false report," which includes "intentional misrepresentation or concealment of a known fact which is made with the intent to deceive" [ALJ Ex. 2]. The Department was required to show that Respondent knowingly and intentionally concealed the fact that he was arrested and charged on March 8th when he filed reports with OPMC. The Hearing Committee concluded that Respondent was aware of his March 8th arrest and charges; and he willfully chose not to declare it on both the Compliance Declaration and Data Sheet he submitted to OPMC [See Discussion & Conclusions - Specification 1&4 Moral Unfitness in the Practice of Medicine; Discussion & Conclusions Specification 13&14 Fraudulent Practice]. Accordingly, the Hearing Committee sustained the Eighteenth and Nineteenth specifications of misconduct. Specification 18&19 - *Sustained*

PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including censure, suspension, probation, imposition of civil penalties and revocation of Respondent's medical license. The evidence shows that Respondent sexually abused Patient H, while he was subject to an Order wherein there were alleged charges of patient abuse and fraud. For this reason alone, the Committee determined that revocation is the only appropriate penalty to protect the public.

Separate and apart from finding that Respondent abused Patient H, the Committee sustained twelve other specifications of misconduct including that Respondent knowingly and with intent to deceive repeatedly violated the Order, and repeatedly and pervasively failed to meet the standard of care in his treatment of his patients. Respondent lacked remorse or accountability for his actions. Accordingly, the Hearing Committee concluded that revocation is the only sanction appropriate to protect the public.

ORDER

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

1. The First, Second, Third, Fourth, Sixth, Ninth, Eleventh, Thirteenth, Fourteenth, Sixteenth, Seventeenth, Eighteenth & Nineteenth Specification of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

2. The Fifth, Eighth, Twelfth, & Fifteenth Specification of professional misconduct, as set forth in the Statement of Charges are **NOT SUSTAINED**.

3. The Respondent's license to practice medicine in the State of New York is **REVOKED**; and

4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail or upon the Respondent at his last known address and such service shall

be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: 8th, **New York**
August , 2017

[redacted]

STEVEN M. LAPIDUS, M.D. - CHAIR
DIANNE SIXSMITH, M.D.
DEBORAH WHITFIELD, M.A, PhD

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APPENDIX A

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

IN THE MATTER

OF

NASIM HAIDER, M.D.

Second Amended
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 27 and February 29 2012

4. On or about November 12, 2013 Respondent submitted to OPMC a "Data Sheet" in which he falsely asserted that "since the effective date of the order" he had not been arrested when in fact he had been arrested on March 8, 2012 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.

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/or 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 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 27 2012 through February 29th 2012 for an immigration physical, and subsequently employed and or trained Patient H as an office worker in his medical practice between on or about February 29 2012, and on or about March 2, 2012.

1. On March 2, 2012, Respondent, in his private medical office, without the consent of Patient / Employee 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. W.T. withdrawn KAD 4/27/17

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 a 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 Respondent maintained a refrigerator in the office that did not have any thermometer monitoring temperature and contained vaccines, and/or specimens collected from patients.

SPECIFICATION OF CHARGES

FIRST THROUGH FORTH 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, and/or h
4. Paragraph A and A 4

FIFTH THROUGH SEVENTH 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:

5. Paragraphs B and B.1, B2 and/or B3.
6. Paragraph H and H 1

~~Paragraph I and I 3~~ withdrawn 4/27/17

EIGHTH THROUGH TENTH 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:

8. Paragraphs B and B.1, B2 and/or B3.

9. Paragraph H and H 1

10. ~~Paragraph I and I 3~~ withdrawn 4/27/17

ELEVENTH 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:

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/or K.

TWELFTH 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:

12. 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/or K.

THIRTEENTH THROUGH FIFTHEENTH 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:

13. Paragraph A. and A.1

14. Paragraph A and A 4

15. Paragraph B and B.4. and or B5

SIXTEENTH 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:

16. 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 .

SEVENTEENTH 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:

17. Paragraph J and any of its subparagraphs.

EIGHTEENTH THROUGH NINETEENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report

required by law or by the department of health or the education department, as alleged in the facts of:

18. Paragraph A. and A.1

19. Paragraph A and A4

DATE: February 24, 2017
New Rochelle, New York

[redacted]

Roy Nemerson, Deputy Counsel
Bureau of Professional Medical Conduct