NEW YORK STATE OF OPPORTUNITY. Department of Health

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KRISTIN M. PROUD
Acting Executive Deputy Commissioner

May 25, 2022

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leslie Eisenberg
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Paul E. Walker, PLLC
315 West 106th Street, Suite 1A
New York, New York 10025

Ogedi Ohajekwe, M.D.
1 Pondfield Road West
Bronxville, New York 10708

RE: In the Matter of Ogedi Ohajekwe, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 22-126) 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.

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 Respondent or the Department may seek a review of a committee determination.

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:

Jean T. Carney, 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 Judge Carney 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]

Dawn MacKillop-Soller
Acting Chief Administrative Law Judge
Bureau of Adjudication

DXM: cmg
Enclosure

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

IN THE MATTER **OF** **OGEDI OHAJEKWE, M.D.**	**DETERMINATION** **AND** **ORDER** BPMC-22-126

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("the Department"). A Notice of Hearing ("NOH") and Statement of Charges ("SOC") dated January 19, 2021 and December 22, 2020, respectively, were served on Ogedi Ohajekwe, M.D. ("Respondent"). Respondent filed an Answer, dated February 22, 2021. A multi-day hearing was held pursuant to N.Y. Public Health Law ("PHL") §230, New York State Admin. Proc. Act ("SAPA") §§301-307 and 401, and Part 51 of Title 10 of the New York Codes Rules, and Regulations (NYCRR) remotely via Cisco Webex. The charges were amended at the June 21, 2021 hearing date, and an October 22, 2021 Second Amended Statement of Charges ("Second Amended SOC") (Exhibit 1a) replaced the amended SOC.

Kenneth J. Steier, D.O., Chair, David M. Kirshy, M.D., and Heidi B. Miller, PA-C, duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Committee" or "Panel") in this matter. Administrative Law Judge ("ALJ") Ann Gayle served as the Administrative Officer. The Department appeared by Kathy Marks, Esq., General Counsel, by Leslie Eisenberg, Associate Counsel. The Respondent appeared by Paul E. Walker, Esq., PLLC. Evidence was received, witnesses testified, and a transcript (p. 1-1240) of this proceeding was made.

The parties provided the Committee with post-hearing submissions. The Department's Proposed Findings of Fact and Conclusions of Law and Respondent's Post Hearing Submission were received on January 11, 2022. The parties' Reply Briefs were received on January 19, 2022. The ALJ and attorneys had several discussions regarding substituting and correcting words and phrases, typos, and misspellings in the transcript. Documents containing the transcript corrections and revisions for hearing dates March 22, April 12, May 17, and June 21, 2021, marked ALJ Exhibits VI, VII, VIII, and IX, respectively, were provided to the Committee prior to deliberations.

Deliberations were held on January 31, February 7, February 23, February 28, and April 13, 2022. Despite Respondent's characterizing the January 7, 2022 submission as "Findings of Fact and Conclusions of Law," the Committee found the document to be similar to Respondent's counsel's November 15, 2021 closing argument. The Committee therefore determined to analyze the Department's 146 Proposed Findings of Fact, incorporating Respondent's arguments where appropriate, and in so doing, adopted some of the Department's findings as written, discarding some in whole or in part, and rewriting or revising others to reflect the testimony and exhibits in evidence. The Department, in its closing argument (transcript page 1217) and Proposed Findings (page 1), stated that it is the Committee's duty to analyze the documents, imaging on disc, and testimony in forming its decision which "is made just as [the Committee] would make any decision in [its] daily life … consider [its] own life experience and use common sense to determine what is accurate and truthful." This Determination and Order ("D&O") predominantly follows the order of the Department's Proposed Findings, sometimes changing the order to have continuity of a particular treatment date or type of treatment, and sometimes combining sequential and non-sequential proposed findings.

After consideration of the entire record, the Hearing Committee issues this Determination and Order; all findings, conclusions, and determinations are unanimous unless otherwise stated.

PROCEDURAL HISTORY

Date of Service of NOH and SOC:	February 1, 2021
Answer Filed:	February 22, 2021
Pre-Hearing Conference:	March 3, 2021
Hearing Dates (2021):	March 22 April 12 May 17 June 21 September 20 September 27 November 8 November 15
Witness for Petitioner:	Claude Roland, M.D.
Witnesses for Respondent:	Respondent David A. Mayer, M.D.
Deliberations Dates:	January 31, 2022 February 7, 2022 February 23, 2022 February 28, 2022 April 13, 2022

STATEMENT OF THE CASE

The Department's Second Amended SOC charged Respondent with fourteen specifications of professional misconduct under N.Y. Educ. Law §6530 which included: fraudulent practice §6530(2); negligence on more than one occasion §6530(3); gross negligence §6530(4); incompetence on more than one occasion §6530(5); gross incompetence §6530(6); willfully making or filing a false report §6530(21); and inadequate record keeping §6530(32). Respondent denied the factual allegations and specifications. As and for an affirmative defense,

Respondent requested that the charges be dismissed in the interest of justice. Educ. Law §6530.

FINDINGS OF FACT

The following Findings of Fact ("FOF") were made after a review of the entire record in this matter. Citations in parentheses, which refer to exhibits ("Ex") that were accepted into evidence and transcript page numbers ("T"), represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Respondent was authorized to practice medicine in New York State on July 22, 1993, by the issuance of license number 193038 by the New York State Education Department. (Ex 2)

General Principles and Standards

2. The standard of care that a reasonably prudent physician should follow when evaluating a patient includes taking and noting a chief complaint, history that includes history of present illness, past medical history ("PMH"), past surgical history, social history, medications, allergies, review of systems, physical examination ("PE"), laboratory studies, differential diagnosis, findings, assessment, and plan. (T 33-34)
3. When a patient presents with symptoms related to vascular disease, the standard of care for a vascular surgeon's evaluation of the patient must include documentation of the most relevant medical problems that would impact the risk-benefit analysis that needs to be put together to determine whether somebody is a candidate for intervention. Such information includes other medical conditions, history, PE, and non-invasive testing. (T 34-35)
4. A medical consultant is a specialist who can be called to opine and advise on a particular case. The consulting physician's responsibility is no different than any other reasonable physician caring for a patient. A consultation includes a comprehensive evaluation including

all pertinent information relating to the presentation, ordering tests that help render an opinion and the potential risks and benefits of various treatment options. A vascular consultant must indicate a clear and reasonable assessment of the peripheral arterial disease so care can be coordinated with all other providers. (T 217, 326-328)

5. The standard of care for a vascular surgeon evaluating a patient for vascular disease must include an adequate history to parse out what symptoms the patient has and whether the symptoms are due to vascular disease. An adequate history includes questions about each symptom such as: What is the distribution? How long have they had them? What's the severity? What makes it better? Worse? Do the symptoms interfere with activities of daily living? If so, how severe? What medications are they taking for them and have they helped? Do they smoke, etc.? Such details help a provider determine if the patient's symptoms are a result of symptomatic vascular disease or some other cause. (T 35, 40-41)
6. The standard of care for a vascular surgeon evaluating a patient for vascular disease includes an appropriate PE. An adequate PE includes vital signs, a cardiopulmonary exam, checking for carotid bruits, an abdominal exam including abdominal bruits, and examination of the skin looking for petechiae or erythema. Whether the patient has atrial fibrillation, a murmur, carotid, or abdominal bruits are all factors to be considered by the practitioner who must determine if intervention is warranted. The examination also needs to include the extremities, pulses and motor and sensory exams. (T 41-45)
7. The standard of care for a vascular surgeon evaluating a patient should include a differential diagnosis. This is important because a patient can have symptoms that seem like vascular disease and those diagnoses can be compounded by vascular disease but the symptoms may be related to other medical conditions and not warrant intervention. (T 36, 58)

8. When evaluating a patient, a vascular surgeon should perform non-invasive testing tailored to the specific findings of the patient or clinical presentation. (T 43-44, 52-54)
9. Peripheral Arterial Disease ("PAD") can be found on a spectrum. Claudication is the next level of PAD and is defined as either pain, numbness, or weakness in the lower extremity which occurs at a predictable distance, is worst when walking on an incline and usually resolves within a few minutes of rest. This occurs when oxygen demand to the muscles is not being met due to impaired arterial flow. (T 49-50, 50-52, 636)
10. Medical records serve many purposes. Most importantly, medical records reflect a patient's complaints and the response to those complaints, documentation of the objective findings related to those complaints, and the assessment of those complaints including differential diagnoses, and then a treatment plan. Medical records should include all those elements for legal reasons, and so all practitioners can understand the direction of the patient's treatment. Lastly, a clear and thorough medical record helps the practitioner maintain a logical sequence of subjective/objective findings, assessment, and plan, and can help a practitioner organize their thoughts to help with a logical appropriate solution. Clear and thorough medical records also help the practitioner with recall from one visit to the next. (T 60-61, 1055)

Patient A

11. Respondent treated Patient A from approximately August 2017 to March 2018. Patient A was a middle-aged female with chronic kidney disease, hypertension, neuropathy, coronary artery disease, diabetes, tobacco and illicit drug use (phenyl cyclohexyl piperidine or "PCP"). She was hospitalized numerous times prior to 2017 for several complaints that included paronychia of the finger, which elevated to drug-seeking behavior, and abdominal pain. (Ex 4a; T 31-32)

12. Respondent first encountered Patient A on August 4, 2017, when he was called as a consultant to evaluate her upon her admission to Montefiore Mount Vernon Hospital ("MMV") for her complaints of abdominal pain and pain and numbness of the left foot for about one week. On admission, her urine was positive for PCP and her blood sugar was 680. (Ex 4a, p. 965; Ex D, p. 965; T 32-33, 220, 228, 632)
13. Respondent performed a consultation on August 4, 2017, and dictated a fairly comprehensive note which included reason for consultation, history of present illness, PMH, PE, impression, and plan which included out-patient vascular workup and documentation that he discussed this with Patient A. Respondent addressed Patient A's abdominal pain by commenting that she did not have any. Respondent noted claudication of less than one block. Respondent failed to note Patient A's chronic kidney disease. During her August 4, 2017 admission, Respondent failed to note that Patient A had stage 3 chronic kidney disease, coronary artery disease, and was a smoker. (Ex 4a, p. 1029, 1050; T 33-38, 56, 227-230, 276-277, 636)
14. Patient A was well-known to Respondent by the time he saw her on August 23, 2017. At that visit, Respondent utilized non-invasive vascular testing, *i.e.*, a Doppler; and he wrote a comprehensive note, but he failed to mention any lab results. (Ex 4a, p. 1520, 1541, 1712; T 68-69, 74)
15. Respondent performed a Doppler ultrasound which showed occlusion and which he documented to describe the basis for his next step. Respondent then performed a procedure for acute thrombosis in the setting of chronic arterial insufficiency which improved Patient A's symptoms. (Ex 4a, p 1541-42; 1712; T 68, 78, 637-639)
16. At 11:13 PM on August 23, 2017, Respondent took Patient A to the operating room to perform an aortogram; the procedure was converted to an open procedure 30 minutes later.

Exhibit 14 shows Respondent was taking pictures of the limb; the angiographic images show evaluation of Patient A's entire leg from proximal femoral artery to the ankle. (Ex 4a; Ex 14; T 77, 79, 91)

17. Respondent documented his attempts and inability to perform an up-and-over the aorta in his August 23, 2017 Operative Note on page 1536. The Department commented, "*It is rare for a vascular surgeon to fail to pass up-and-over the aorta except for where there is a lot of calcified disease*." This is inaccurate; there are other reasons as well. Dr. Mayer and Respondent testified about this, and even Dr. Roland acknowledged it. The Department further commented, "*Failure to successfully perform an up-and-over is not in and of itself a deviation of minimally accepted standards of care but failing to document the reason(s) for such failure is a deviation from standard of care*." Respondent did mention this in the Procedure section of the Operative Note on page 1536, and there was nothing wrong with what Respondent did. (Ex 4a, p 1536; T 105-108, 641-644, 970-972)
18. Respondent did not see Patient A following the August 23/24, 2017 procedure due to events that were outside his control. Furthermore, Respondent performed a bypass, and he cannot be blamed for the bypass in the other leg. (Ex 4a; Ex G; T 108-110, 645-647)
19. Patient A was transferred to another facility on August 27, 2017, and ultimately had a below knee amputation and then an above knee amputation (Ex 4a, page 1434, 2138)
20. Patient A was readmitted to MMV on January 21, 2018, with complaints of bilateral leg pain for 4 weeks, and abdominal pain. On January 23, 2018, Respondent performed a consultation. (Ex 4a, page 2138; Ex F, page 2115, 2181, 2208; T 646)
21. Patient A was not a new patient when Respondent saw her on January 23, 2018. Respondent had been seeing Patient A for many months; she was well known to him. Patient A had

sonogram imaging previously on August 23, 2017. On January 23, 2018, Respondent documented details of the pain, and he palpated pulses and checked for capillary refill. Not noting "*if Patient A had a prosthetic or used a wheelchair or some other assistive device*" is not relevant. The Department criticized, "*Respondent failed to perform and/or note an adequate physical examination and evaluation of Patient A ... [and that his] 'failure' to take and/or note an appropriate history deviated from minimally accepted standards of care.*" This criticizes Respondent as if each time Respondent sees Patient A she's a new patient. Respondent is not seeing a new patient. (Ex F, page 2181-82; 1712; T 267-268, 647-648)

22. On January 24, 2018, Patient A had a CT angiogram, whereby contrast was injected throughout the body and images were obtained as the contrast flowed through the arteries. The person reading the CT scan (Ex 4a, p 2436-2437) can see where there is blood flow through the arteries. The images seemed to indicate areas of blockage that likely impaired blood flow. The Department wrote, "*...and the lower vessels in the ankle and foot were blocked by bone, so it was not possible to gather data for that anatomy.*" This is inaccurate as the report shows that the dorsalis pedis artery was seen (page 2437). The CT angiogram showed that the anterior tibial artery was occluded in the mid-calf area where there was no flow, but the flow reconstituted below the blockage. (Ex 4a, p 2185, 2436-2437; Ex F, p 1707; Ex 15; Ex 19, disc series 6 and 7)
23. Respondent adhered to the standard of care by performing a comprehensive PE and history for Patient A on January 23, 2018. (Ex 4a, p 2181, 2215). After performing the sonogram, it was appropriate to perform a CT angiogram as Respondent did. (Ex 4a p 2436-2437)
24. Respondent wrote an extensive progress note on January 23, 2018, regarding the diagnosis he was considering at the time. The Department wrote, "*Respondent wrote a progress note in*

Patient A's chart on January 25, 2018, in which he documents the plan to perform an intervention the next day. However, he failed to document an appropriate indication for any intervention, he failed to perform and/or note a physical exam, and he failed to indicate any diagnosis that he was considering at that time (Ex 4a, p. 2215-2216, 2233-2235; T 133-136, 140-142, 280)." Since an extensive note was written two days prior, there was no need to repeat that information in order to be considered adequate. (Ex 4a, p. 2181)

25. On January 26, 2018, Respondent performed an angiogram by accessing the common femoral artery with a needle and catheter, during which he obtained images of the right leg arteries from groin to ankle. Because Respondent was not able to get across the blockage (that happens) he stopped the procedure until snares could be obtained. Contrary to the Department's comment, "*Respondent did not document his thought process which is a deviation from standard of care,*" Respondent did document his impressions and thought process. (Ex 4a, p 2234-2235; Ex 16; Ex 19).

26. Respondent documented the angiogram procedure, but he failed to note in the operative report the catheter and wire size used during the procedure. Respondent documented that an introducer sheath was used and he documented how access was obtained (p. 2234). Respondent noted a wire gauge of .036[1]. Respondent pushed the wire through the catheter which went through the wall of the tibio-perineal artery. Respondent failed to include the extravasation in his operative report. Although the fact that there was an extravasation is <u>not</u> a deviation from standard of care, failing to document it is a deviation from minimally accepted standards of care. Further, the medical record and anesthesia reports indicate that an angioplasty was done but Respondent makes no mention of an angioplasty. None of this is

[1] *Dr. Roland thought this could be a typo (T 138, 149, 161)*

clearly noted in the operative report which is a minor deviation from the standard of care[2]. (Ex 4a, p. 2234-2235; T 138-140, 149-151, 159-161)

27. Respondent noted seeing Patient A on January 27 and 29, 2018. At these visits, Respondent failed to document the puncture site, his physical examination of the right lower extremity, and labs particularly related to Patient A's renal function. This fell below the minimally accepted standard of care, as did Respondent's documentation of the follow-up visit. (Ex 4a, p 2244-2245, 2265-2266; T 162-164)

28. On January 30, 2018, Respondent took Patient A back to the operating room and performed an angiogram. (Ex 4a, p 2354-2355)

29. Respondent appropriately documented the January 30 angiogram. Respondent attempted – unsuccessfully– to cannulate the anterior tibial artery, and the attempts were described in the operative note (*see* Exhibit 4a, p 2354 paragraphs 3 and 4 under Procedure). Respondent indicated how the arteries were accessed: via the common femoral artery using a Size 6 Introducer Sheath. Respondent made incisions over the dorsalis pedis artery on the foot and behind the ankle to pass a wire into these arteries to try to advance a wire through the blockage and then capture the wire from above with a snare. Respondent noted that after the cutdown, he then did an angioplasty but there are no details of an angioplasty in the operative note. Further, Respondent noted "good results were noted in both." This is inaccurate; the images from the angiogram show that the flow is diminished in the lower leg. (Ex 4a, p 2354-2355; Ex 17; Ex 19; T 164-170, 175, 182-183, 343)

30. In this case, the Department's expert initially made presumptions about what Respondent did during the January 30 angiogram (T 173, lines 10-11). However, upon further questioning, he

[2] *Dr. Roland testified this is "probably on the lower scale of deviation from standard of care." (T161)*

stated, "there is no presumption" (T 174, lines 7-8 and 25 to T 175, line 2). The images from the January 30 angiogram show a worsening of flow in the severely diseased tibioperoneal trunk. Yet, Respondent noted good results in both. (Ex 4a, p 2354-2355; T 187-192, 343)

31. Respondent saw Patient A the following day, January 31, 2018, and he noted that the foot was warm and capillary refill was acceptable. (Ex. 4a, p. 2310-2311)

32. Endovascular treatment follow-up, as outlined by the Vascular Surgeon's Guidelines, recommends performing a clinical exam, an ABI, and a Duplex study within the first month. In addition, according to the Guidelines of the Society for Vascular Surgeons, continued surveillance at three months and then at six-month intervals beginning after the three-month follow-up should be considered. This is done both to see if there is a change from pre-treatment status and to determine a current baseline. Dr. Roland testified that the "Society of Vascular Surgeons guidelines …give us guidelines that we can follow. It's not the rule of the land" (T 198). After intervention in January 2018, Respondent did not see Patient A one month after because Patient A failed to keep the appointment. Respondent saw Patient A in his office on March 15 and March 19, 2018, during which he performed a focused post-operative clinical examination. On March 15, 2018, Respondent wrote, "wounds are healed very well, continue with Plavix and exercise as much as possible." (Ex 3, p. 9-12; T 197-201, 285-286, 705-708, 723-725)

33. Respondent appropriately recommended and performed intervention on Patient A in January 2018. Patient A was well known to Respondent. Patient A had demonstrated severe peripheral vascular disease with history of left below knee amputation. Respondent, familiar with Patient A's history and pathology, was justified in proceeding to an angiogram. (Ex 4a)

34. Dr. Roland answered "no" when asked on cross examination whether Patient A's reported reduction in pain after the January 2018 surgery was due to Respondent's intervention. Based on questions from the panel, Dr. Roland went on to explain that Patient A's complaints of pain in both extremities was more consistent with diabetic neuropathy than with ischemia, which is why he was reluctant to say that the patient had rest pain or pain at rest, which are vascular diagnoses. Dr. Roland explained that although Patient A did have severe and diffuse PAD, the presence of that disease did not necessarily mean it was the cause of her symptoms. While Dr. Roland testified that Patient A's improvement was serendipitous and not related to the procedure, this was disproven as documented by multiple other providers in the record. (Ex 4a; Ex J, p 2294, 2302, 2308, 2310-2311, 2325, 2332-2333, 2352-2353; T 282-290, 302-305, 320-323, 334-337, 343-347,349-351)

35. In response to panel questions, Dr. Roland testified that Respondent's care and treatment was grossly negligent. However, the record shows that Dr. Roland agreed Respondent was correct in taking Patient A to the operating room on August 23, 2017, and Respondent treated her right leg within the minimum standard of care. (Ex 4a; T 315-322)

Patient B

36. Respondent initially saw Patient B in his office on August 18, 2017, for evaluation of his legs prior to a scheduled kidney transplant. Respondent's documented chief complaint from Patient B was "I have titanium in both legs, and I don't work too well." Patient B's other medical conditions included atherosclerosis, renal failure, diabetes, hypertension, reflux, atrial fibrillation for which he was on an anticoagulant, encephalopathy, a septic shoulder, and an IVC filter. (Ex 5, p 20; T 538-539)

37. Respondent evaluated Patient B at the initial visit on August 18, 2017. Respondent documented information about Patient B at this visit including past medical history and surgical history, cardiopulmonary exam, medications, symptoms of pain in lower extremities and a thorough physical exam including evaluation of pulses in the lower extremities. Respondent's note addressed the issue of shortness of breath and recent weight gain by ruling out congestive heart failure on his physical exam. On physical exam, Respondent noted Patient B was not in any significant distress, had no jugular venous distension, chest reveals good entry and moved symmetrically with respiration, and he had normal heart sounds. (Ex 5, p 20-22; T 539-540, 582-583, 759)

38. Respondent did not repeat or reorder previously performed non-invasive testing of vascular disease to determine the nature and extent of Patient B's PAD as it was already documented. Respondent's judgment was that regardless of ABI or arterial duplex study results, Respondent recommended Patient B undergo a CT angiogram of aorta and lower extremities. This CT angiogram was also needed for evaluation of Patient B for upcoming renal transplant. Furthermore, the insurance company approved the medical necessity of the CT angiogram. (Ex 5, p 20-22, 42; Ex 6a; T 539-541, 582-586, 759-762)

39. Patient B returned to Respondent's office nine weeks later, on September 28, 2017, reporting that he went into a coma and was hospitalized for ten days. Respondent noted that he is in a wheelchair, has worsening PAD in the lower extremities, and now has cholecystitis. Respondent planned to perform a cholecystectomy and the next day, he booked an ambulatory surgical unit for October 18, 2017, to perform a laparoscopic cholecystectomy. For various reasons, the cholecystectomy was never performed (Ex 5, p 17, 19; T 542-543, 817-822, 1093-1095)

40. Respondent failed to adequately document his physical examination of Patient B on September 28, 2017, which by a 2-to-1 vote, fell below the minimally accepted standard of care (Ex 5, p 19). Respondent's prescription order of the same date is for medical clearance, chest x-ray, and complete lab work. (Ex 5, p 17, 19, 47; T 542-544, 817-822, 1098-1099)
41. On December 18, 2017, Patient B was transported by ambulance to MMV due to changed mental status and pain in both feet. On admission, he was noted to have gangrene at the 2nd toe on the left foot. Podiatry consult was requested and they concluded that surgical intervention was likely once vascular optimized and there was full demarcation. (Ex 6a, p 832; Ex 6a.1, p 808, 836; T 544-546)
42. Respondent's initial consultation with Patient B in MMV was on December 20, 2017, for evaluation of gangrene on the toes of the left foot. Respondent adequately documented his evaluation of Patient B in this consultation. (Ex 6a, p 889-890; T 546-547, 823-825)
43. Respondent provided appropriate indications for performing an angiogram, *i.e.*, Patient B's gangrenous toes and left foot ulcer, and in preparation for a renal transplant. Respondent appropriately recommended an angiogram with possible intervention; it was scheduled for December 22, 2017. (Ex 6a, p 888-890, 910; Ex K, p 848-850, 889-890, 921, 931-932; T 546-547, 763-768)
44. Over the course of the next several days, Patient B's gangrene worsened. Podiatry and Respondent continued to see Patient B. (Ex 6a)
45. On December 27, 2017, Respondent took Patient B to the operating room and performed an aortogram, bilateral iliac artery angiogram, and a left lower extremity run-off, which are all diagnostic, and an atherectomy which is therapeutic. Respondent's noted indication for the procedure was bilateral ischemic ulcer of the toes in addition to left foot ischemic ulcer and

the need to evaluate the iliac arteries prior to renal transplant. Respondent decided not to evaluate the right leg because of Patient B's history of renal failure and the fact that the left leg was worse than the right. Respondent testified, "This patient, as we have been discussing, is a very brittle patient, very sick. He is a patient you want to be in and out of the hospital. The patient is already on dialysis, so you want to inject as little as [sic] contrast as you can. The reason for doing angiogram of the aorta and the iliac is to rule out disease in the upper part, which more or less I kind of imagined that there was a good chance it was going to be normal. Once that was done, my plan was to concentrate on the leg that had the disease" (T 830, lines 4-17) [and] "Just the fact that he had issues on both of the lower extremities, at least at the skin level, but from my recollection the issue on the right side did not warrant as much attention of the left side at this point." (T 785, lines 14-17). (Ex 6a, p 1055; T 548-549, 769, 785)

46. As per paragraph #2 of the December 27, 2017 operative note (Ex K, p 1055), Respondent manipulated the guidewire over the bifurcation into the left side and advanced the catheter through which he performed an angiogram of the rest of the left lower extremity. During the December 27 procedure, Respondent identified disease in the tibial vessels, distal to the popliteal artery, and he decided to intervene through the perineal artery. It was reasonable to try to improve flow below the ankle resulting in some improvement in the foot. To that end, Respondent performed an atherectomy, whereby he removed plaque from a blood vessel using a catheter. It is standard of care that after doing an atherectomy, a completion angiogram is performed to see what the results of the atherectomy are, and to determine whether there had been distal embolization. Respondent did a completion angiogram as is evidenced by the images of the disc, specifically image 41/41, on page 7 of Exhibit 18.

Respondent documented that he performed an atherectomy and angioplasty of the anterior tibial artery. Images of the distal left leg and foot were either not obtained or not submitted into evidence. (Ex 6a, p 889, 1055; Ex 18; Ex 20; T 569, 578-580, 610-611, 769-773)

47. During the December 27 procedure, there were several instances in which Respondent was unable to perform an up-and-over technique. It is not uncommon for a vascular surgeon to fail to perform an up-and-over technique, and it is not a negative reflection on his technical skills. (Ex 20; T 574-577, 771-772)

48. The December 27 angiogram revealed a "desert foot" meaning there is very poor blood supply below the ankle where the chances of salvage are questionable. There were differences in opinion between Respondent and Podiatry regarding the likely success of doing a forefoot amputation. (Ex 6a, p 1208, 1221, 1224, 1237, 1238; Ex 18; Ex 20; T 563, 595-600, 606)

49. Respondent's December 29 follow-up visit, two days after having performed a diagnostic and therapeutic procedure on the patient, was a focused surgical note that evaluated the puncture site and lower extremity. (Ex 6a, p 1148)

50. After the intervention on December 27, Patient B's condition worsened. This is consistent with Respondent's initial and ongoing evaluation, assessment, and treatment plan for the severity of Patient B's peripheral vascular disease. (Ex 6a, p 1120, 1122-23, 1148; T 550, 777-781)

51. On January 4, 2018, after Respondent recommended a trans-metatarsal amputation, Podiatry was asked to provide a second opinion. The second opinion, given on January 5, was that the patient would benefit from a below the knee amputation due to extensive increasing gangrenous changes and the entire left foot was cool to the touch. Podiatry noted that their

review of the lab results and the angiogram led them to conclude that any podiatric procedure in the foot would likely result in further worsening ischemic changes, and healing potential for any surgery in the foot was extremely guarded. (Ex 6a, p 1221, 1224, 1237; Ex 6a.1, p 1236; T 554, 781-787)

52. After the patient's family agreed to the below the knee amputation on January 5, Respondent operated on Patient B on January 8, 2018. Respondent inserted a PICC line, removed hardware from the left tibia, and performed the below the knee amputation. During the procedure, Respondent "began cutting the bone and realized that there was intramedullary rod." Upon discovering the rod, Respondent called for an orthopedic consult. The titanium rod was well-known to Respondent from Patient B's telling Respondent and Respondent documenting it in the angiogram procedure. (Ex 6a, p 1238, 1251, 1293, 1302-1303, 1341; T 789, 826-828, 1104-1105)

53. Patient B expired in MMV on January 19, 2018. (Ex 6a, p 1482; T 555-556)

Patient C

54. Patient C's initial encounter with Respondent was at his office on May 24, 2018, resulting from a referral to Respondent for management of a hemostasis wound. Patient C had recurring ulcers on her lower extremities. In addition to PAD, Patient C had a history of diabetes and a trans-metatarsal amputation. (Ex 7, p 7-9, 18; T 359-360, 384, 388, 391, 848-853, 1111-1114)

55. Ulcerations can persist for years and can heal and then return. The presence of PAD can impact the healing of ulcerations. (Ex 7; T 365-366, 388, 849-850)

56. On May 24, 2018, Respondent performed and documented an appropriate evaluation of Patient C including past medical history, past surgical history, medications, allergies, social

history, and a physical examination including the wound. Respondent did not perform noninvasive arterial testing because he believed she would not tolerate ABI, as per her sensitivity when he unwrapped the bandage. (Ex 7, p 7-9, T 360-361, 851-852, 858)

57. In his notes for the May 24 examination, Respondent described the ulcers as being secondary to chronic venous stasis. Respondent noted "previous bypass" had been performed. (Ex 7, p 8-9; T 360, 391, 849-850)

58. Respondent performed and adequately documented his May 24 evaluation of Patient C. (Ex 7, p 7-9; T 366, 392, 850-852)

59. Respondent personally performed a venous evaluation which showed evidence of prior greater saphenous vein ablation at her thigh levels. There was some dilatation of the lower thigh and leg veins on both sides. (Ex 7, p 9; T 851, 867-869, 903)

60. After performing a noninvasive sonogram, Respondent appropriately performed a right lower extremity angiogram on Patient C on June 16, 2018, using an antegrade approach by inserting a catheter into an artery in the leg in question, the right leg. (Ex 7, p 11; Ex 7-a; T 852-854)

61. Respondent appropriately utilized an antegrade approach for angiography of Patient C as it would minimize the amount of contrast in this diabetic patient. (Ex 7, p 11; T 1119)

62. Patient C returned to see Respondent in his office for follow-up visits on July 3 and August 7, 2018. On July 3, Respondent failed to adequately document his evaluation of Patient C in follow-up since he failed to note an adequate history by not documenting her symptoms; there was no indication as to how she was feeling and the condition of the wound. Respondent failed to note an adequate physical exam and did not note vital signs, medications, or perfusion in the leg. Respondent failed to objectively describe what the

wound looked like and how the groin was healing. The documentation of the July 3 follow-up visit fell below minimally accepted standards. (Ex 7, p 10 and 12; T 378-379)

63. Respondent's record of the June 16, 2018 procedure accurately reflects the care rendered to Patient C. Patient C's medical record reflects details from the procedure performed on June 16, including antegrade approach in the right groin and local Lidocaine anesthetic. Respondent testified that only Lidocaine was used and stated that no conscious sedation was given. (Ex 7, p 11; T 865-866)

64. Respondent noted on the June 8, 2018 visit that Patient C reported that she had arterial studies showing evidence of arterial disease. The report, if it exists and/or if Patient C provided it to Respondent, was not available at the hearing. (Ex 7a)

65. Respondent further failed to maintain a record that accurately reflects the care rendered to Patient C since the record has some inaccuracies. For example, on August 7, 2018, Respondent noted that the patient had good capillary refill to the toes when she did not have toes on one foot. There are also notes indicating the patient underwent angioplasty, but she did not. Respondent referenced Patient C's symptoms before and after the diagnostic angiogram. This appears to be a point-in-time marker, not a cause-and-effect relationship. (Ex 7, p 12; T 365-372, 380-381, 402)

Patient D

66. Respondent first saw Patient D at his office on May 1, 2018. Patient D was referred to Respondent by Dr. Naik after Dr. Naik saw Patient D on April 17, 2018, for complaint of severe pain in her left leg. The referral note indicated she had a "Left Femoral DVT." Although the onset of pain was an acute event, the referral does not indicate whether it was

an acute or chronic DVT (deep vein thrombosis). (Ex 8, p 17, 41, 43-46; T 414-415, 434-435, 456)

67. Patient D had been on Eliquis, an anticoagulant since August 2017, for atrial fibrillation. Respondent noted on the May 1 visit that she continued to have severe pain in the left lower extremity emanating from the left hip area. (Ex 8, p 41, 43-46; T 414-415, 434-435)

68. Respondent reported and noted an adequate evaluation of Patient D. He noted that Patient D had pain from the left hip which could be consistent with a proximal DVT in the left femoral vein. Respondent did not document details or questions regarding compliance with Eliquis. (Ex 8, p 41, 43-45; T 414-415)

69. Respondent performed and documented in Exhibit 8, page 45 an adequate evaluation of Patient D including an adequate physical examination. The absence of swelling, tenderness, or dilated veins does not rule out venous thrombosis. Furthermore, (Ex 8, p 41) Respondent performed a venous sonogram on May 1, 2018 which showed the patient has evidence of left femoral deep vein thrombosis, and the right side is within normal. (Ex 8, p 3-5, 41, 43-45, 49-57; T 417, 870-873)

70. An IVC (inferior vena cava) filter is a medical device that is inserted to reduce the risk of fatal pulmonary embolism and can be inserted based on a failure of medical therapy or where this is a contraindication for anticoagulation. Respondent concluded that Patient D had a DVT while on an anticoagulant and therefore needed an IVC filter. After Respondent adequately evaluated Patient D by performing a physical exam and Doppler ultrasound which showed DVT, and considered Patient D's past history of DVT, anticoagulation history, and Patient D's current symptoms, Respondent inserted an IVC filter. (Ex 8; T 415, 423-424, 873-875, 1130-1131, 1134-1137)

71. In response to the question of what possible alternative therapies could have been employed for Patient D, Dr. Roland testified, "Based upon my impression of the patient's presentation, I would not have inserted an [IVC]." (T 426). When asked if he agreed with Dr. Roland's testimony, Respondent testified, "No… Like I stated, it would be catastrophic in this patient with all these conditions; being overweight; strong family history. The patient was on treatment for anticoagulation for [DVT], that's what I would have given her as if I made diagnosis of [DVT] without being on anticoagulation. Adding all of this together, I would not say it would make sense not to do it." (T 875). This testimony adds further justification to Respondent's assessment and treatment plan for Patient D. (Ex 8; T 426, 875, 1134-1137)

72. On May 8, 2018, in his office, Respondent performed a procedure in which he inserted a permanent IVC filter. Prior to placing a permanent filter, a reasonably prudent physician must look at and consider all of the variables and try to make a prudent decision. Respondent acted as a reasonably prudent physician under the circumstances; see previous FOF ## 70 and 71. (Ex 8, p 29; T 426-429, 435-437, 441-451, 456-459, 875)

73. Patient D returned to Respondent's office for follow-up on May 15, 2018, and then returned to see Respondent again on November 8, 2018. In November, Patient D saw Respondent to discuss removal of the IVC filter based on her concern that the filter was not in the correct location and that it caused her abdominal pain. Patient D also reported that she was frustrated that she had to postpone an MRI of her left knee (which was bothering her) due to the insertion of the filter. Respondent appropriately ordered x-rays to assess the location of the filter. (Ex 8, p 32, 33, 42; T 430-431, 877-878)

74. Respondent adequately evaluated Patient D on November 8, 2018, and he ordered abdomen and chest x-rays to confirm correct positon of the IVC filter. (Ex 8, p 32, 33; T 431, 877-879)

Patient E

75. Patient E was referred to Respondent by Dr. Hunter-Brown for evaluation of her pain and a mass in her left leg. On April 27, 2018, Dr. Hunter-Brown ordered an ultrasound; the ultrasound was performed by Radiology and identified a mass in the anterior leg. The radiology report indicated no arterial flow and a well-circumscribed echoic mass with no evidence of aneurysm or simple cyst. An MRI was suggested for further evaluation. Patient E then saw Respondent in his office on May 18, 2018. (Ex 9, p 1, 16-19, 20-23; T 466-470, 892-893, 1139-1140)

76. Respondent adequately evaluated Patient E on May 18, 2018. He performed a focused history and physical examination. The sonogram showed a 13.2 mm dilated segment of a superficial vein in the lateral mid left leg with a central organized thrombus. Based on these results, Respondent did not believe an MRI was indicated. (Ex 9, p 16-21; T 468-471, 893-894, 1140-1143)

77. As part of Respondent's evaluation of Patient E, he reasonably performed an ultrasound. This exam on May 18, 2018, was one of the two Duplexes performed on Patient E. Patient E had a left lower extremity duplex sonogram at MMV on April 27, 2018. Patient E had a second duplex sonogram on May 18, 2018 by Respondent at her first office visit. Respondent noted the results as "no significant reflux on either side, however, she has dilated segment of a superficial vein with organized thrombus." This impression, which is not inconsistent with other findings in the medical record, such as outside radiology ultrasound performed approximately one month apart, was Respondent's documented indication for performing Endovenous ablation. (Ex 9, p 19-21; T 469, 484, 893-894, 1140-1143)

78. Respondent performed an Endovenous ablation on Patient E's GSV (Greater Saphenous Vein) in his office on July 31, 2018. Venous ablation is a procedure that can be done surgically or with a catheter, and is used to treat symptomatic venous disease such as thrombus, pain, swelling, skin changes, phlebitis, itching and/or ulcerations. The purpose of performing such a procedure is to destroy the vein that is causing symptoms or skin ulceration. (Ex 9, p 13-14; T 472-474, 894-895)

79. It was appropriate for Respondent to perform venous ablation on Patient E. There are other criteria in addition to reflux or insufficient veins, such as acute isolated superficial vein thrombosis, for doing so. (Ex 9, p 13-14, 19; T 471-474, 486-487, 895, 1142-1143)

80. Respondent successfully treated Patient E's condition which was a thrombosis, not a mass, by performing EVLT (endovascular laser treatment). (Ex 9; T 479-484, 893-896, 1142-1143)

Patient G[3]

81. Patient G was referred to Respondent by Dr. Adubor for evaluation of a left arm fistula and was seen by Respondent in his office on May 12, 2017. Respondent noted that Patient G stated, "He wants to have lesions excised." (Ex 11, p 20-22; T 499, 910)

82. A fistula is where a vein is sewn into an opening in an artery so the flow within the vein can be high enough to accommodate needles that are used for dialysis treatment. A graft is a synthetic tube that is used to connect an artery and a vein and serves the same purpose as a fistula. The risks of complications are different and the management of an area of dilation for which the patient presents might have been different. The terms "fistula" and "graft" were used interchangeably by Respondent. (Ex 11; T 501)

[3] *The Department withdrew its Charges regarding Patients F and H during the course of the hearing.*

83. Respondent performed an adequate history and focused physical exam on Patient G on May 12, 2017. (Ex 11, p 20- 22; T 1146-1147)

84. Patient G returned to see Respondent in his office one year later on May 3, 2018. Patient G reported having a procedure at another facility (See FOF # 86) and was complaining of pain, at night, in the other (right) arm. Respondent performed a focused history and physical exam on Patient G. Respondent noted that the graft is patent and functioning well, but the patient has swelling and pain. He recommended observing the access and intervening if surgical indications develop, such as a thrombosis or unbearable pain. (Ex 11, p 18, 53, 67; T 509-510, 913-915)

85. Although Respondent recommended waiting and watching, approximately four weeks later, on May 29, 2018, Respondent performed a ligation and inserted a new graft at MMV. The brief operative report indicated the reason for the procedure was aneurysmal dilatation and impending rupture. (Ex 11, p 16-18; T 915)

86. There is no operative note regarding the 2017 procedure (See FOF #84) in Patient G's chart; Respondent did not perform this procedure. The operative note of Respondent's 2018 procedure is in Patient G's chart. (Ex 11, p 17; T 522, 914, 922, 930-931, 1149-1150)

Licensure Registration Renewal Applications

87. Respondent was under a legal obligation to pay child support in the years 2011, 2013, 2015, and 2017. Yet, in each of those years when completing his Registration Renewal Application that he submitted to the New York State Department of Education ("NYSED"), Respondent answered "No" to the question, "Are you under an obligation to pay child support?." (Ex 2; T 674-677)

COMMITTEE VOTE

Patient A

Factual Allegation A.1.b. reads, "Respondent … failed to … perform and/or note an adequate history and physical examination."

Factual Allegation A.1.b is dismissed for "failed to perform."

Factual Allegation A.1.b is dismissed for "failed to note an adequate history" by a 2-1 vote**

Factual Allegation A.1.b is sustained for "failed to note an adequate physical examination" in the January 27 and 29, 2018 visits and portions of the January 26, 2018 operative note (FOF ## 26 and 27).

Factual Allegation A.1.h, failure to maintain a medical record that accurately reflects the care and treatment rendered is sustained.

Factual allegations A.1.c-g and A.2 are dismissed.

Factual allegation A.1.a is dismissed by a 2-1 vote**

Patient B

Factual allegation B.1.b. reads, "Respondent … failed to … perform and/or note an adequate history and physical examination."

Factual Allegation B.1.b. is dismissed for "failed to perform."

Factual Allegation B.1.b is dismissed for "failed to note an adequate history" by a 2-1 vote**

Factual Allegation B.1.b is sustained for "failed to note an adequate physical examination" in the September 28, 2017 visit by a 2-1 vote (FOF # 40).

Factual Allegation B.1.h, failure to maintain a medical record that accurately reflects the care and treatment rendered is sustained by a 2-1 vote.

Factual allegations B.1.e-g and i and B.2.a and b are dismissed.

Factual allegations B.1.a, c, and d are dismissed by a 2-1 vote**

Patient C

Factual Allegation C.1.a. reads, "Respondent … failed to … perform and/or note an adequate evaluation."

Factual allegation C.1.b. reads, "Respondent … failed to … perform and/or note an adequate history and physical examination.

Factual Allegations C.1.a. and b. are dismissed for "failed to perform."

Factual Allegations C.1.a. and b. are sustained for "failed to note" in the July 3, 2018 visit (FOF # 62).

Factual Allegation C.1.c, failure to maintain a medical record that accurately reflects the care and treatment of the patient is sustained.

Factual allegations C.2.a and b are dismissed.

Patient D

Factual Allegation D.1.e, failure to maintain a medical record that accurately reflects the care and treatment of the patient is sustained.

Factual allegations D.1.a, c and D.2 are dismissed.

Factual allegation D.1.b is dismissed by a 2-1 vote**

Factual allegation D.1.d is dismissed by a 2-1 vote. The dissenting vote believed the catheter was invasive and risky.

Patient E

All factual allegations, E.1.a-c and E.2, are dismissed.

Patient G

All factual allegations, G.1.a and b and G.2, are dismissed

**The dissenting vote would have sustained for the "failure to note" aspect of those allegations.

CONCLUSIONS OF LAW

Respondent is charged with fourteen Specification of Charges of professional misconduct under Educ. Law §6530. The Committee sustains the Fifth and Seventh through Tenth Specifications and dismisses the First through Fourth, Sixth, and Eleventh through Fourteenth Specifications, as described below.

Gross Negligence – Educ. Law §6530(4).

The first and second specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing medicine with gross negligence with respect to Patients A and B.

"Gross negligence," in the specific context of a professional misconduct proceeding, may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach ("Rho"). 74 N.Y.2d 318, 322, 546 N.Y.S.2d 1005 (1989).

No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these

words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient. Post v. State of New York Department of Health, 245 A.D.2d 985, 986, 667 N.Y.S.2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct. See Minielly v. Commissioner of Health. 222 A.D.2d 750, 751, 634 N.Y.S.2d 856 (3d Dept. 1995).

The Committee is sustaining allegations of ordinary negligence with regard to Patients A and B (see below). The Committee finds these few sustained allegations, for negligent recordkeeping only, do not constitute "multiple acts of negligence that cumulatively amount to egregious conduct." Additionally, the Committee does not find "a single act of negligence of egregious proportions" in Respondent's care and treatment of Patients A and/or B.

Accordingly, the first and second specifications of gross negligence are not sustained.

Gross Incompetence – Educ. Law §6530(6)

The third and fourth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing medicine with gross incompetence with respect to Patients A and B.

Gross Incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences. Post, supra, at 986.

Since the Committee is not sustaining allegations of ordinary incompetence with regard to Patients A and/or B (see below), there could not be gross incompetence.

Accordingly, the third and fourth specifications are not sustained.

Negligence on More Than One Occasion – Educ. Law §6530(3)

The fifth specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing medicine with negligence on more than one occasion with respect to Patients A through E and G.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S.2d 381 (3d Dept. 1993). Injury, damages, and proximate cause are not essential elements in a medical disciplinary proceeding (Id.)

The statutory definition of "negligence" for professional misconduct requires proof of negligence "on more than one occasion." Educ. Law §6530(3). The Court of Appeals has interpreted "occasion" to mean "an event of some duration, occurring at a particular time and place, and not simply …a discrete act of negligence which can occur in an instant." Rho, supra at 322. While several acts of negligence occurring during a single autopsy do not constitute professional misconduct (Rho), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct. Orosco v. Sobol, 162 A.D.2d 834, 557 N.Y.S.2d 738 (3d Dept. 1990).

While the Committee concluded that the majority of the factual allegations were not sustained, the sustained factual allegations identified in the Second Amended SOC as A.1.b., B.1.b., and C.1.a. represented failures by Respondent on some occasions to exercise the care that a reasonably prudent physician under the circumstances would exercise regarding recordkeeping. For Patient A, the Panel finds FOF # 26 and 27 for dates January 27 and 29, 2018, rise to the level of negligent recordkeeping, not negligent practice. For Patient B, the Panel finds by a 2-to-1 vote that FOF # 40 for the date September 28, 2017, rises to the level of negligent

recordkeeping; the Panel unanimously finds this was not negligent practice. For Patient C, similar to Patient A, the Panel finds FOF # 62 for the date of July 3, 2018, rises to the level of negligent recordkeeping, not negligent practice. Hence negligence on more than one occasion was sustained for negligent recordkeeping only.

Accordingly, the fifth specification is sustained based on some of the recordkeeping findings that rose to the level of falling below the minimum standard of care for recordkeeping, thus constituting negligence on more than one occasion.

Incompetence on More Than One Occasion – Educ. Law §6530(5)

The sixth specification charged Respondent with committing professional misconduct as defined in Educ. Law §6530(5) by practicing medicine with incompetence on more than one occasion with respect to Patients A through E and G.

Incompetence is a lack of the requisite skill or knowledge to practice medicine safely. (Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996)). The statutory definition requires proof of practicing with incompetence "on more than one occasion." N.Y. Educ. Law §6530(5). "On more than one occasion" in relation to incompetence would presumably carry the same meaning as it does in relation to negligence on more than one occasion, discussed above.

Based on Respondent's testimony, in conjunction with its careful review of the records, the Committee finds Respondent to have the requisite *knowledge* to practice medicine safely. The Committee also finds Respondent to have the requisite *skill* to practice medicine safely.

Accordingly, the sixth specification is not sustained.

Record Keeping – Educ. Law §6530(32)

The seventh to twelfth specifications charged Respondent with committing professional misconduct as defined in Educ. Law §6530(32) by failing to maintain a record which accurately reflects the evaluation and treatment of the patient with respect to Patients A through E and G.

The Committee accepts that the axiom in medicine, "if it's not written it wasn't done," is frequently the case. However, the Committee finds it does not apply here based on its careful review of the records and Respondent's testimony. The care and treatment provided by Respondent for these patients, as testified to by Respondent and corroborated in a review of the records established that Respondent provided more care and treatment for them than is reflected in their records. This, combined with Respondent's overall knowledge of medicine, and the correctness of the tests, studies, procedures, and treatment he ordered, performed, and provided, convinced the Panel that this axiom should not be applied to each and every visit/encounter in this case.

Additionally, while there is not necessarily a different standard or threshold for surgeons' versus other practitioners' recordkeeping, the Committee, consistent with the Department's suggestion to "consider its own life experience and use common sense to determine what is accurate and truthful" (T 1217), found Respondent's notes to be similar to how most surgical/operative notes are written; they were focused notes. Dr. Mayer also addressed this (T962-963; 1048-1049).

Pursuant to FOF ## 2, 3, and 4, records must include:

FOF #2: a chief complaint, history of present illness, social history, past medical and surgical history, medications, allergies, review of systems, physical examination, laboratory studies, differential diagnosis, findings, assessment, and plan.

FOF #3: (for vascular surgeons) documentation of the most relevant medical problems that would impact the risk-benefit analysis that needs to be put together to determine whether somebody is a candidate for intervention, including other medical conditions, history, PE, and non-invasive testing.

FOF #4: (for a vascular consultant) indication of a clear and reasonable assessment of the peripheral arterial disease so care can be coordinated with all other providers.

Based on FOF ## 2, 3, and 4, the Panel found enough of this information lacking in Patients A, B, C, and D's charts to accurately reflect those patients' course while under Respondent's care, and sustained this charge for those four patients. See FOF ## 13, 14, 26, 27, 29, 30, 40, 62, 65, and 68.

Accordingly, the seventh, eighth, ninth and tenth specifications are sustained, and the eleventh and twelfth specifications are not sustained.

Fraudulent Practice

The thirteenth specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently with respect to answers Respondent gave in his 2011-2013, 2013-2015, 2015-2017, and 2017-2019 NYSED Registration Renewal Applications ("Registration Applications").

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Matter of Choudhry v. Sobol, 170 A.D.2d 893, 894, 566 N.Y.S.2d 723, 725 (3d Dept. 1991), citing Matter of Brestin v. Commissioner of Education, 116 A.D.2d 357, 359, 501 N.Y.S.2d 923, 925 (3d Dept. 1986). In order to sustain a charge that a licensee was engaged in the fraudulent

practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (3d Dept. 1966), aff'd 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must specifically state the inferences it is drawing regarding knowledge and intent. Choudhry, at 894, citing Brestin. See also, Adler v. Bureau of Professional Medical Conduct, 211 A.D.2d 990, 622 N.Y.S.2d 609 (3d Dept. 1995; Berger v. Board of Regents, 178 A.D.2d 748; 577 N.Y.S.2d 500 (3d Dept. 1991).

The Committee finds that in Respondent's "no" answer to the question in the Child Support section of each Application, "Are you under an obligation to pay child support?" (1) a false representation *was* made; the Committee was not convinced that (2) Respondent *knew the representation was false*; and the Committee did not find that (3) the licensee *intended to mislead* through the false representation. With (1) Respondent was under such obligation; (2) Respondent's interpretation that there was no longer an "obligation" once he paid the child support is plausible; and (3) because Respondent's interpretation was plausible, the Committee did not believe there was sufficient evidence from which it could infer that Respondent *intended to mislead* NYSED when he answered those questions as he did.

Accordingly, the thirteenth specification is not sustained.

Making or Filing False Reports

The fourteenth specification charged Respondent with committing professional misconduct as defined in 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 with respect to answers he gave in his NYSED Application.

To make a finding of a Respondent willfully making or filing a false report, a committee must establish that a licensee made or filed a false statement willfully, which requires a knowing, intentional or deliberate act, Matter of Brestin v. Commissioner of Education, 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986). Merely making or filing a false report, without intent or knowledge about the falsity fails to constitute professional misconduct, Brestin (supra). The law provides, however, that a committee may reject a licensee's explanation for erroneous reports (such as errors resulting from inadvertence or carelessness) and draw the inference that the licensee intended or was aware of the misrepresentation with other evidence as the basis. (See Brestin).

The Committee determines that Respondent's "no" answer to the question in the Child Support section of each Application, "Are you under an obligation to pay child support?" was false, but as previously stated, because the Committee found Respondent's interpretation that there was no longer an obligation once he paid the child support to be plausible, the Committee does not believe there was sufficient evidence that his "no" answer was "a knowing, intentional or deliberate act." (Brestin, supra).

Accordingly, the fourteenth specification is not sustained.

DISCUSSION

Credibility and Weight

The Department presented one witness, Claude Roland, M.D., to testify as an expert witness. Respondent testified in his own behalf and presented David A. Mayer, M.D., to testify as an expert witness. Both Dr. Roland and Dr. Mayer had the requisite knowledge, experience

and credentials to render expert opinions.

The Panel found Dr. Roland did not always address the standard of care; he often testified about what he would do/how he would do it. The Panel found Dr. Roland's testimony about Respondent's care and treatment of the patients at times to be too aggressive, overreaching, with "tunnel vision" or from the perspective of "Monday morning quarterbacking." That said, Dr. Roland did help the Panel see how to evaluate the cases. At times Dr. Roland alluded to the fact that Respondent acted appropriately, which was fair in those instances.

With regard to Respondent's January 31 and February 1, 2018 notes in Patient A's chart that her condition improved and her pain was reduced (FOF ## 31 and 34):

Dr. Roland answered "yes" to Respondent's counsel's question,

> "Are you telling us that you think it's just serendipitous that the patient went from 8 to 10 out of 10 pain for four weeks in her leg, had her operation by [Respondent] and subsequent to that operation has much less pain. You think that just happened serendipitously as opposed to this being a cause and effect to the surgery; is that where you are?" (T 290).

Dr. Roland later answered "yes" when asked by a Panel member,

> "Do you think that the reporting is inaccurate, that there is some sort of dishonesty here?" (T 344).

For this testimony, Respondent's counsel suggested the Panel follow the principle in common law, *falsus in unum*, "...if the [fact finder] finds that a witness has lied about one significant fact, the [fact finder] can disregard everything that witness said on the ground that one who lies about one thing might well lie about everything. ... The [fact finder] does not have to disregard everything, but they can if they so desire." Reply brief, page 2. The Panel does not adopt this principle for Dr. Roland's testimony.

Although the Panel gave credit and weight to some of Dr. Roland's testimony, the aforesaid findings and observations made it difficult for the Panel to give his testimony much

weight in many circumstances.

The Panel found Dr. Meyer to have good credentials but his testimony was discounted in large part because he did not seem to know much about the patients at issue in this hearing.

The Committee found Respondent to be credible. The Committee did not agree with any criticism of Respondent's (and Dr. Meyer's) training. Respondent kept his skills current and trained for seven years including taking time off to do research for two years. He was re-credentialed every two years at the hospital so he had to have fulfilled CME to be re-credentialed.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

Respondent's attorney argued that the Department has not carried its burden of proof for the charges and therefore the Committee should not sustain the charges. The Department argued that all the factual allegations and specification of charges should be sustained and Respondent's license to practice medicine in NYS should be revoked. The Committee finds dismissal of the charges is not warranted. There is misconduct and a penalty is required.

Having dismissed most specifications and the majority of the allegations, the Committee concludes that what was sustained does not warrant a revocation of Respondent's license. In fact the Committee, most cognizant of its duty to protect the public, believes that removing Respondent from practice would be a disservice to, and not a protection of, the public. The Committee strongly believes the charges were out of proportion to Respondent's performance, and although the Panel believes Respondent was overcharged, the Panel is concerned about Respondent's not conceding a single allegation including any of his recordkeeping.

The Committee found Respondent to be compassionate; he at times went above and beyond; and he worked in an underserved community treating very difficult patients, those who might never improve. All patients require and deserve proper care, and Respondent gave it.

Respondent was very task oriented. He had the ability to evaluate the patients and come to the right conclusions. He ordered/performed the right tests and studies, considered tests and studies already performed by himself or other practitioners, and then proceeded to treat the patients in accord with the results.

Patients A and B were very difficult, complicated patients. Patient A had spasm and nothing was flowing but she still had a leg several months later when she returned to Respondent. Negligence and recordkeeping were sustained for Patients A and B. The negligence on more than one occasion was sustained for negligent recordkeeping only.

The Panel does not believe that its finding, "The titanium rod was well-known to Respondent from Patient B's telling Respondent and Respondent documenting it in the angiogram procedure" (FOF # 52) rose to any definition of misconduct. The Panel concludes that Respondent forgot about the rod (this happens) and more importantly, once he noticed he took immediate, appropriate action by calling for an orthopedic consult.

Negligence and recordkeeping were sustained for Patient C. The negligence finding was for negligent recordkeeping only.

Recordkeeping was sustained for Patient D. Factual allegation D.1.b. alleging that Respondent's care and treatment deviated from minimally accepted standards of care in that he failed to perform and/or note an adequate history and physical was dismissed by a 2-1 vote wherein the dissenting vote was based on lack of documentation only. With that allegation

dismissed, the Panel then unanimously sustained the recordkeeping charge for Patient D, but did not find that this recordkeeping rose to the level of negligent recordkeeping.

No charges were sustained for Patients E and G. The Panel concluded that Respondent's interchanging of a fistula and a graft (which are similar but have some potential differences) in Patient G's record (FOF # 82) does not rise to the level of misconduct.

Respondent has a history with OPMC (Office of Professional Medical Conduct) and this Board (BPMC). (Exhibits 23, 24, 25, 26, L, and M; T 734-744, 805-816, 837-839, 840-845). That history is:

--An August 27, 2015 non-disciplinary Order of Conditions (BPMC Order No. 15-212) was issued. This Order, *inter alia*, required a practice monitor for three years. (Ex 23)

--On November 28, 2018, OPMC informed Respondent that effective September 9, 2018, he was no longer required to have a practice monitor or to maintain enhanced medical malpractice insurance as previously required by BPMC Order No. 15-212. (Ex M)

--A few months earlier, an August 30, 2018 non-disciplinary Interim Order of Conditions (BPMC Order No. 18-187) was issued. This Order, *inter alia*, restricted Respondent's practice to the extent that he was not permitted to perform any invasive procedures in his office until an infection control consultant determined that he had complied with remediating the concerns. (Ex 24)

--A December 14, 2018 non-disciplinary Amended Interim Order of Conditions (BPMC Order No. 18-278) was issued. This Order revised the August 30, 2018 Interim Order. (Ex 25)

--Upon OPMC's Director's determination that Respondent "complied with the recommendations and remediation plan made by an independent infection prevention and infection control consulting firm," a July 15, 2019 non-disciplinary Second Amended Order of Conditions (BPMC Order No. 19-177) was issued. This Order deemed some of the conditions in the aforesaid Order(s) no longer in effect while other conditions remained in effect. (Ex 26)

--On October 2, 2020, OPMC's Director informed Respondent that BPMC Order No. 19-177 was no longer in effect due to OPMC's determination that Respondent had satisfied the Order's terms and conditions. (Ex L)

The Applications to the Board for the aforesaid Orders were signed by Respondent. His then attorney, Department attorneys, and OPMC Director agreed to the proposed terms and conditions. Each Application contained language that "the Department of Health shall notify the National Practitioner Data Bank and the Federation of State Medical Boards of [the Order] … the change in [Respondent's] licensure status is NOT disciplinary in nature (emphasis added)… [and the Order] shall be posted on the Department of Health website(s)." (Exhibits 23, 24, 25 and 26)

The Committee carefully weighed both Respondent's history with this Board and OPMC and the relatively few findings it sustained in determining the penalty for this matter. The allegations regarding Patients A through E, and G arose during the three years when Respondent was subject to a non-disciplinary order which required that he could practice medicine "only when monitored by a licensed physician" (BPMC Order No. 15-212). The Department argued, "he has already been through the process, more than once. There is no reason to believe that another opportunity to continue to practice with oversight, will make any difference in his medical practice." (Department's brief, final paragraph before "Findings of Fact"). That argument assumes that the numerous allegations of negligence, gross negligence, incompetence, gross incompetence and recordkeeping, and perhaps even fraudulent practice and making or filing false reports, would be sustained. They were not.

Each case before a Committee of the Board must be decided on the totality of the evidence before it. A penalty must be commensurate with the findings/charges sustained and must balance the Respondent's rights with the protection of the public. A history with this Board/OPMC and multiple allegations for few or many patients, in and of itself or combined, do not automatically mandate a severe penalty. This is true for a disciplinary or non-disciplinary

history. Respondent's history is non-disciplinary, and this Committee did not sustain the vast majority of the allegations. The vast majority of the allegations were dismissed.

While there were no catastrophic outcomes, the Board is tasked with imposing a penalty that prevents Respondent from repeating his previous mistakes. The Committee balanced protecting the public with giving Respondent a chance with direction to help him improve. The Committee found fault in Respondent's care and treatment of four patients. The fault was recordkeeping, some of which rose to the level of negligent recordkeeping for a finding of negligence. For that the Committee finds Respondent is not a danger to the public, and he deserves another opportunity to continue to practice.

The findings in this case, some inadequate recordkeeping for four of the six (initially eight) patients charged, with a few of those recordkeeping findings rising to negligent recordkeeping, do not warrant the need for a monitor for Respondent. OPMC has the power and authority within the attached probation terms to "review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices" (Probation term #6). The Panel finds this to be sufficient oversight of Respondent for the misconduct sustained in this matter.

The Panel believes aspects of Respondent's practice can be improved, particularly with recordkeeping, and that Respondent can benefit from training by taking in-person CME (continuing medical education). Respondent is encouraged to, at a minimum, consistently document, in addition to SOAP (Subjective, Objective, Assessment, and Plan), patients' vital signs and that he looked at the studies/imaging/lab results.

The Committee meticulously scrutinized the 1,200-page transcript and all exhibits during its close to 30 hours of deliberations on five dates as well as numerous hours preparing for each deliberation date. Having done this and having considered the full range of penalties available pursuant to PHL §230-a, the Committee determined the appropriate penalty to be (1) a censure and reprimand; (2) a requirement for Respondent to complete in-person CME courses in recordkeeping, patient safety, and electronic recordkeeping; and (3) probation for two (2) years.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Educ. Law §6530 are sustained:

   §6530(3) – practicing with negligence on more than one occasion (Patients A, B, C)
   §6530(32) – failure to maintain an accurate record (Patients A, B, C, D).

2. The following charges of misconduct under Educ. Law §6530 are not sustained:

   §6530(2) – practicing fraudulently
   §6530(4) – practicing with gross negligence
   §6530(5) – practicing with incompetence on more than one occasion
   §6530(6) – practicing with gross incompetence
   §6530(21) – filing a false report
   §6530(32) – failure to maintain an accurate record (Patients E and G).

3. Pursuant to PHL §230-a(1) Respondent shall be censured and reprimanded.

4. Pursuant to PHL §230-a(8) Respondent shall take courses totaling at least 20 hours in medical recordkeeping, patient safety, and electronic medical records. These courses shall be taken within the first nine (9) months of the effective date of this order. These courses shall be taken in-person if available.

5. Pursuant to PHL §230-a(9) Respondent shall be placed on Probation for a period of two (2) years. Terms of Probation are attached to this Determination and Order as Appendix 1.

6. This order shall be effective upon service on the Respondent by personal service or by certified mail as required under PHL §230(10)(h)

DATED: Middletown, New York
May 24 2022

[redacted]

KENNETH J. STEIER, D.O., Chair
DAVID M. KIRSHY, M.D.
HEIDI B. MILLER, PA-C

To:

Leslie Eisenberg
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Paul E Walker, PLLC
315 West 106th Street, Suite 1A
New York, New York 10025

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

IN THE MATTER

OF

OGEDI OHAJEKWE, M.D.

SECOND AMENDED

STATEMENT

OF

CHARGES

Ogedi Ohajekwe, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 22, 1993, by the issuance of license number 193038 by the New York State Education Department. Respondent maintains a private practice ("office") located at 1 Pondfield Road West, Bronxville, NY 10708.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from in or about August 2017 through in or about March 2018. Respondent saw Patient A on August 4th, for a vascular surgery consult in Montefiore Mount Vernon Hospital (MMV), related to her complaints of abdominal pain as well as pain and numbness in her left foot, for a week. Patient A was readmitted to MMV and on August 23, Respondent performed a surgical procedure for an acute thrombosis. Four days later, Patient A was transferred to another facility for left foot salvage surgery and she subsequently had her left leg amputated. Patient A was readmitted to MMV, on January 21, 2018, with complaints of right leg pain, for four weeks. Respondent saw Patient A in consult, on January 23, 2018. On January 26th, Respondent performed an angiogram via an ipsilateral approach, without success, and discontinued the procedure because no snare was available. On January 30th, Respondent performed another procedure that included an angiogram and

angiography. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:
   a. perform and/or note an adequate evaluation,
   b. perform and/or note an adequate history and physical examination,
   c. utilize standard testing of vascular disease and/or respond to lab results,
   d. provide appropriate indications for intervention,
   e. adequately and appropriately follow-up on the patient after surgery in August 2017 and January 2018,
   f. recommend and/or implement non-surgical treatment,
   g. successfully perform endovascular treatment from a contralateral puncture,
   h. maintain a medical record that accurately reflects the care and treatment rendered to the patient.
2. Inappropriately recommended and/or performed surgery without medical indication.

B. Respondent treated Patient B from in or about August 2017 through in or about January 2018. Respondent first saw Patient B, in his office, on August 18th in anticipation of a kidney transplant. Respondent recommended a CT angiogram. Respondent saw the patient, in his office, on September 28th and then again, in MMV, on December 20, 2017, after Patient B was hospitalized for ischemic changes in his left foot, associated with altered mental status. On December 27, 2017, Respondent performed a left leg angiogram and tibial angioplasty and then on January 8, 2018, he performed a left below the knee amputation. Respondent's care and treatment of the patient deviated from minimally accepted standards of care in that he:

1. Failed to:
   a. perform and/or note an adequate evaluation,
   b. perform and/or note an adequate history and physical examination,
   c. utilize standard testing of vascular disease and/or respond to lab results,
   d. provide appropriate indications for intervention,

e. adequately and appropriately follow-up on the patient,

f. perform angiogram of the right lower extremity on December 27, 2017 based on his note indicating bilateral ischemic ulcers of toes,

g. successfully perform endovascular treatment from a contralateral puncture,

h. maintain a medical record that accurately reflects the care and treatment rendered to the patient,

i. perform a completion angiogram after atherectomy on December 27, 2017.

2. Inappropriately:

a. proceeded with intervention on December 27, 2017,

b. recommended a trans-metatarsal amputation, based on the patient's condition.

C. Respondent treated Patient C from in or about May 2018 through in or about August 2018. On May 24, 2018, Respondent saw Patient C, in his office, in consult for right leg wound associated with venous and arterial insufficiency. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:

a. perform and/or note an adequate evaluation,

b. utilize standard testing including but not limited to noninvasive arterial and venous testing,

c. maintain a record that accurately reflects the care and treatment of the patient.

2. Inappropriately:

a. performed surgical procedure without medical indication,

b. utilized an antegrade approach for angiography.

D. From in or about May 2018 through in or about November 2018, Respondent treated Patient D, who was chronically anticoagulated for atrial fibrillation, for complaints of leg pain emanating from the left hip area, attributed to a deep vein thrombosis. On May 8, 2018, Respondent placed a permanent Inferior Vena Cava

(IVC) filter via the common femoral vein. Patient D returned to Respondent on November 8, 2018 with complaints of abdominal pain, attributed to the placement of the IVC filter. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:
   a. perform and/or note an adequate evaluation including but not limited to determining whether the patient had an acute or chronic condition,
   b. perform and/or note an adequate history and physical exam,
   c. recommend and/or implement alternative therapies,
   d. appropriately assess the patient regarding her complaint of abdominal pain in November 2018,
   e. maintain a record that accurately reflects the care and treatment of the patient.
2. Inappropriately recommended and inserted an IVC filter without appropriate diagnostic testing and/or without initially trying non-surgical alternatives.

E. Respondent treated Patient E from in or about May 2018 through in or about August 2018, in his office, with endovenous ablation of the great saphenous vein (GSV). Patient E presented with complaints of pain and a lesion in her left leg. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:
   a. perform and/or note an adequate evaluation,
   b. recommend and/or perform excision of the lesion,
   c. maintain a record that accurately reflects the care and treatment rendered to the patient.
2. Inappropriately performed ablation of the GSV without medical indication.

F. Previously Withdrawn

G. Respondent treated Patient G from in or about January 2017 through in or about July 2018. Patient G was treated for arteriovenous fistula. Respondent's care and treatment deviated from minimally accepted standards of care in that he:

1. Failed to:
   a. perform and/or note an adequate history and physical exam,
   b. maintain a record that accurately reflects the care and treatment of the patient.
2. Inappropriately performed surgical procedure(s) without medical indication.

H. *Previously Withdrawn*

I. On or about June 28, 2011, September 16, 2013, September 23, 2015, and July 31, 2017, Respondent filed a Registration Renewal Application with the New York State Education Department for his New York Medical License for the registration periods of 2011-2013, 2013-2015, 2015-2017 and 2017-2019. In each of these renewal applications, Respondent answered "no" to the question, "Are you under an obligation to pay child support?" even though he was, in fact, under an obligation to pay child support during those years. Respondent answered "no" knowing, or having reason to know, and with intent to mislead, that his answer of "no" was false.

SPECIFICATION OF CHARGES

FIRST-SECOND SPECIFICATIONS

GROSS NEGLIGENCE

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

1. Paragraph A and its subparagraphs.
2. Paragraph B and its subparagraphs.

THIRD-FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraph A and its subparagraphs.
4. Paragraph B and its subparagraphs.

FIFTH 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:

5. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph G and its subparagraphs.

SIXTH 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:

6. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph G and its subparagraphs.

SEVENTH-TWELFTH SPECIFICATIONS

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:

7. A (1)(h)

8. B (1)(h)

9. C (1)(c)

10. D (1)(e)

11. E (1)(c)

12. G (1)(b)

THIRTEENTH 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 I.

FOURTEENTH 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:

14. Paragraph I.

DATE: October 22, 2021
New York, New York

[redacted]
HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct

APPENDIX 1

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of his license with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204 with the following information, in writing, and ensure that this information is kept current: a full description of his employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with and respond in a timely manner to OPMC requests to provide written periodic verification of his compliance with these terms. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if he is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30-day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in the Determination and Order or as are necessary to protect the public health.

6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

7. Respondent shall comply with these probationary terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these

terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.