New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Patrick F. Carone, M.D., M.P.H.
Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

August 18, 1998

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Aspet Haruthunian, M.D.
10 Longwood Road
Port Washington, New York 11050

RE: License No. 112296

Dear Dr. Haruthunian:

Enclosed please find Order #BPMC 98-183 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **August 18, 1998.**

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Hedley Park Place, Suite 303
433 River Street
Troy, New York 12180

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Robert Asher, Esq.
295 Madison Avenue
New York, New York 10017

Terrence Sheehan, Esq.

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

IN THE MATTER

OF

ASPET HARUTHUNIAN, M.D.

SURRENDER

OF

LICENSE

BPMC #98-183

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

ASPET HARUTHUNIAN, M.D., being duly sworn, deposes and says:

On or about June 7, 1972, I was licensed to practice medicine as a physician in the State of New York having been issued License No. 112296 by the New York State Education Department.

My current address is 10 Longwood Road, Port Washington, New York , and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that I have been charged with 12 specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I do not contest the Third through the Seventh Specifications in full satisfaction of the Statement of Charges.

I hereby make this application to the State Board for Professional Medical Conduct and request that it be granted.

I understand that, in the event that the application is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such application shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued striking my name from the roster of physicians in the State of New York without further notice to me. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Surrender Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Surrender Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

AFFIRMED:

DATED 7/31/98

RESPONDENT ,M.D.

The undersigned agree to the attached application of the Respondent to surrender his license.

Date: 7/31/98

, Esq.
Attorney for Respondent

Date: 8/3

TERRENCE SHEEHAN
Associate Counsel
Bureau of Professional
Medical Conduct

Date: August 6, 1998

ANNE F. SAILE
Director
Office of Professional Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER :

OF : ORDER

ASPET HARUTHUNIAN, M.D. :

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Upon the proposed agreement of Aspet Haruthunian, M.D. (Respondent) to Surrender his license as a physician in the State of New York, which proposed agreement is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this Order shall take effect upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Surrender Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED,

DATED: August 10, 1998

Patrick F. Carone, M.D.

Patrick F. Carone, M.D., M.P.H.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

ASPET HARUTHUNIAN, M.D.

STATEMENT

OF

CHARGES

ASPET HARUTHUNIAN , M.D., the Respondent, was authorized to practice medicine in New York State on or about June 7,1972, by the issuance of license number 112296 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between in or about June, 1986 and in or about December, 1995, Respondent treated Patient A, a 30 year old female, at Respondent's medical office at 571 Academy Street, New York, New York ("the Clinic"). (The names of patients are contained in the attached Appendix.)

1. Respondent failed to obtain and note adequate histories and to perform and note physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed or ordered:

   a. X-rays of Patient A's chest, neck, hips, knee and thoracic spine.

   b. EKG's

c. Laboratory studies including, Chem Profile, RPR, serum zinc, serum iron, unsaturated serum iron capacity, total iron binding capacity and Transferrin % saturation.

d. NSAID's, including Relafen, Solumedral and Day Pro, in a patient who has peptic ulcer disease.

e. Rocephin IM for a simple URI.

f. Spirometry performed with a steroid as a bronchodilator.

g. IM Solumedral and Marcaine.

3. Patient A complained of persistent epigastric pains. Respondent ineffectively treated this condition for over a year. Respondent should have but failed to refer Patient A to a gastroenterologist.

4. Respondent failed to provide routine preventative care to Patient A, including PAP smears.

5. Respondent failed to maintain a medical record for Patient A which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

B. Between in or about January, 1990 and in or about January, 1995, Respondent treated Patient B, a 52 year old female, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed or ordered:

   a. Parenteral antibiotics.

   b. Intra-articular injections of steroids.

   c. X-rays of Patient B's hips, chest, shoulder and knees.

   d. EKG's

   e. Laboratory studies including, Chem Profile, Urinalysis, TB skin test, free T3, free T4, Hemoglobin Fractionation and Thyroid Function Panel.

3. Respondent inappropriately placed Patient B on anti hypertensive medication on the basis of a single marginally elevated BP.

4. Respondent improperly treated Paronychia with Rocephin IM and ceftin. The proper treatment is incision and drainage.

5. Respondent failed to provide routine preventative care to Patient B, including PAP smears.

6. Respondent failed to maintain a medical record for Patient B which accurately reflects the care and treatment he provided, including patient complaints, history, physical examination, diagnoses, rationale for tests and a treatment plan.

C. Between in or about January, 1989 and in or about March, 1995, Respondent treated Patient C, a 30 year old female, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed or ordered:

a. X-rays of Patient C's chest and hips.

b. Laboratory studies including, Chem Profile, serum iron, TIBC, CBC, RPR, Free T3, Free T4, and MHA-TP.

c. Parenteral antibiotics

d. Intra-articular injections of steroids.

3. Some of Patient C's presenting complaints were, as noted by Respondent, suggestive of gall bladder disease, yet Respondent failed to order a sonogram to follow up this differential diagnosis.

4. Respondent failed to provide routine preventative care to Patient C, including PAP smears.

5. Respondent failed to maintain a medical record for Patient C which accurately reflects the care and treatment he provided, including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

D. Between in or about October, 1988 and in or about April, 1990, Respondent treated Patient D, a 47 year old female, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed and ordered:

   a. X-rays of Patient D's hips, chest, wrists and hands.

   b. Laboratory studies including T3 Uptake, T4, RPR, Hemoglobin Fractionation and Serum Zinc.

   c. EKG's

d. Intra-articular steroid injections.

e. Benadryl IM

3. Respondent made a diagnosis of pelvic inflammatory disease (PID) which was not indicated. Respondeat improperly failed to perform a pelvic examination or to obtain appropriate cultures.

4. Respondent made a diagnosis of asthma which was not indicated and prescribed a Proventil Inhaler and Theodur which was not indicated.

5. Respondent noted the presence of "cystic hard lesions of the right wrist". Respondent failed to follow-up these findings.

6. Respondent failed to provide routine preventative care to Patient D, including PAP smeárs.

7. Respondent failed to maintain a record for Patient D which accurately reflects the care and treatment he provided, including patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

E. Between in or about January, 1988 and in or about October, 1995, Respondent treated Patient E, a 36 year old male, at the Clinic.

1. Respondent failed to obtain and note adequate histories and to perform and note adequate physical examinations.

2. Respondent inappropriately and without legitimate medical purpose repeatedly prescribed or ordered:

   a. X-rays of Patient E's chest, hands and wrists.

   b. Laboratory studies including, ESR, Free T3, Free T4, Chem Profile, Serum Iron, TIBC, Urinalysis and VDRL.

   c. EKG's.

   d. Intra-articular steroid injections.

   e. Spirometry.

   f. Pneumococcal Vaccine

   g. IM Antibiotics.

   h. Codeine cough syrup.

3. Respondent made the following diagnoses which are not indicated:

a. Asthma
b. Sinusitis
c. Otitis
d. ASHD
e. Bursitis

4. Respondent improperly failed to follow-up a complaint of dysuria despite persistent symptoms.

5. Respondent failed to maintain a record for Patient E which accurately reflects the care and treatment he provided including, patient complaints, history, physical examination, diagnoses, rationales for tests and a treatment plan.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1-A5; B and B1-B6; C and C1 - C5; D and D1-D7; E and E1-E5

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A1-A5; B and B1-B6; C and C1 - C5; D and D1-D7; E and E1-E5 .

THIRD THROUGH SEVENTH SPECIFICATIONS

UNNECESSARY TESTS OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by ordering excessive tests and treatments as alleged in the facts of:

3. Paragraphs A and A2.
4. Paragraphs B and B2.
5. Paragraphs C and C2.
6. Paragraphs D and D2.
7. Parapraphs E and E2.

EIGHTH THROUGH TWELFTH SPECIFICATIONS

FAILURE TIO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

8. Paragraphs A and A5.
9. Paragraphs B and B6.
10. Paragraphs C and C5.
11. Paragraphs D and D7.
12. Parapraphs E and E5.

DATED: July , 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct