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

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

January 6, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001-1803

Anthony Z. Scher, Esq.
Wood & Scher
14 Harwood Court
Scarsdale, New York 10583

Muneer Imam, M.D.
2 Union Avenue
Center Moriches, New York 11934

RE: In the Matter of Muneer Imam, M.D.

Dear Mr. Sheehan, Mr. Scher and Dr. Imam:

Enclosed please find the Determination and Order (No. BPMC-93-01) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

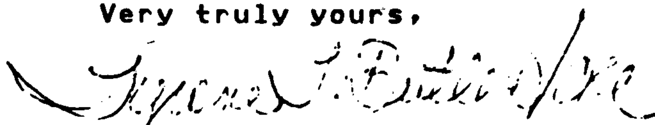
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Very truly yours,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER OF MUNEER IMAM, M.D.	DETERMINATION OF THE HEARING COMMITTEE
	ORDER NO. BPMC-93-01

The undersigned Hearing Committee consisting of **CHARLOTTE S. BUCHANAN, ESQ.**, Chairperson, **STEPHEN A. GETTINGER, M.D.**, and **RICHARD N. PIERSON, M.D.**, was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES**, Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) of the New York Public Health Law and sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Article 131-A of the New York Education Law by **Muneer Imam, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	July 2, 1992
Notice of Hearing returnable:	September 22, 1992
Place of Hearing:	5 Penn Plaza New York, New York
Respondent's answer served:	none
The State Board for Professional Medical Conduct appeared by:	Terrence Sheehan, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York
Respondent appeared in person and was represented by:	Wood & Scher, Esqs. 14 Harwood Court Scarsdale, NY 10583
Hearings held on:	September 22, 1992 October 13, 1992 October 14, 1992
Conferences held on:	September 10, 1992
Deliberations held:	November 23, 1992

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with negligence and/or incompetence on more than one occasion, that he has committed gross negligence, gross incompetence, and kept inadequate patient records. The allegations arise from treatment of some three patients in 1989 and 1990. The allegations are more particularly set forth in the Statement of Charges which is

attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Howard Chester, M.D. Expert Witness

Respondent testified in his own behalf and called these witnesses:

Miquel Blanco, M.D. Expert Witness

Bala Hari Pilai, M.D. Expert Witness

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this State. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this State and thus consistent with accepted standards of medical practice. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. Gross incompetence was similarly defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that

cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or severe deviation from standards.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility. The Committee was further under instructions that with regard to a finding of medical misconduct, it must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be relevant to penalty if any.

Inadequate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

The findings of fact which follow herein, were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in

arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The Petitioner was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. All findings and conclusions herein were unanimous unless otherwise stated.

GENERAL FINDINGS

Respondent, **MUNEER IMAM, M.D.**, is a physician licensed to practice medicine in the State of New York. Respondent has been licensed since July 30, 1984, and is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 2 Union Avenue, Center Moriches, NY 11934 (Ex. No. 1, Statement of Charges).

FINDINGS OF FACT
WITH REGARD TO
PATIENT A

1. Patient A was admitted to Central Suffolk Hospital on or about July 25, 1989 (Ex. #2, p. 47).

2. On that date, Respondent was "on call" for the Department of Medicine. This meant that he was responsible for any patient requiring the services of that department who came to the emergency room and did not have a private

physician affiliated with the hospital. Patient A was not Respondent's regular patient (236-237).

3. Patient A was brought to the hospital via ambulance after having been found on the floor by his wife with various medications strewn about (238; Ex. #2, p. 4).

4. Upon arrival at the hospital, Patient A was in a semi-comatose, stuporous state (239, Ex. #2, p. 4).

5. Respondent was contacted by telephone by the emergency room physician and, after being given a brief history, Respondent issued various orders. This was at about 2:30 in the morning on July 25, 1989 (237-240; Ex. #2, p. 23).

6. Respondent saw Patient A at about 7:00-7:30 am on July 25, 1989. The Patient record shows no history or physical examination for Patient A (244-246).

7. Respondent dictated his history and physical examination but for unknown reasons the hospital chart does not include the history and physical (245-246, 248-9).

8. By the time Respondent saw Patient A, his neurological status had improved markedly. Patient A was more alert; he was sitting in a chair; and he was walking because he demonstrated a "shuffling gait" (241-243; Ex. #2, p. 49).

9. The tentative diagnosis being entertained was drug overdose because of the condition in which Patient A was found and the existence of the medications on the floor

near him (252-255).

10. Respondent ascertained that Patient A had been prescribed *inter alia*, lithium, nortriptyline and Tofranil (252-254; Ex. #2, pp. 4, 49).

11. Respondent also ascertained that Patient A was a diagnosed manic-depressive (252).

12. Respondent conducted several informal consultations with Patient A's treating psychiatrist, Dr. Pedro Sanchez, and reviewed Patient A's prior history. Respondent discussed with Dr. Sanchez his plans to transfer Patient A to the veterans administration hospital (255-257; Ex. #2, p. 6).

13. Patient A's blood was tested for a possible drug overdose. The laboratory reported that the lithium level was 1.4 Meq/l. The therapeutic range of lithium is .5 to 1.3 Meq/l (Ex. 2; p. 16). The toxic range for lithium begins at 1.5 Meq/l (253; Ex. #2, pp. 15 & 16, 49).

14. Respondent did not request a neurological or psychiatric consultation (25-26).

15. Complete blood count was done (Ex. 2, p. 9).

16. Patient A's lithium level was made known to Respondent and based thereon he ordered that Patient A receive lithium for his manic depression (257).

17. After Patient A received two doses of lithium, another drug screen came back from the laboratory and indicated that Patient A's lithium level was 3.2 (261; Ex.

#2, p. 16). Based on this value and because Patient A was acting lethargically, Respondent discontinued the lithium on July 26, 1989 (261-262; Ex. #2, p. 24).

18. Patient A began to have tremors and was acting in a restless and agitated fashion. It was believed that these symptoms were withdrawal symptoms because Patient A was not taking Atavan which he had previously been taking. On or about July 27, 1989, Respondent ordered the administration of Librium to calm the patient and to eliminate the withdrawal symptoms (263-264; Ex. #2, p. 24).

19. On July 29, 1989, Respondent discontinued the Librium (266-267; Ex. #2, p. 25).

20. On or about July 25, 1989, a laboratory report revealed that Patient A was somewhat anemic and that he had an elevated white blood cell count (leukocytosis) (269; Ex. #2, p. 9).

21. Respondent ordered a chest x-ray and urine analysis and culture (270).

22. The initial chest x-ray was clear (no signs of pneumonia) (270). For unknown reasons, the urine analyses and cultures were not done as ordered by Respondent. On or about July 28, or 29, Respondent obtained a new specimen (278).

23. Patient A had a significant urinary tract infection as evidenced by a laboratory report (277; Ex. #2, p. 13). This report was not recorded in the patient's chart

until July 30, 1989 (278; Ex. #2, p. 13).

24. Respondent did not order an EEG or CT scan of the head or a spinal tap for Patient A (274-277; Ex. #2, p. 13).

25. Patient A expired at or about 1:00 am on July 30, 1989 (Ex. #2, p. 4).

CONCLUSIONS
WITH REGARD TO
FACTUAL ALLEGATIONS
CONCERNING PATIENT A

In factual allegation A.1, Respondent is charged with failing to perform a physical examination for Patient A. There is no dispute that a physical examination should have been performed and that no such physical appears in the patient record. The dispute arose over Respondent's claim that he performed the examination, dictated it into the hospital's dictation bank and, due to circumstances beyond Respondent's control, the dictation was never transcribed and placed in the file. The committee was divided on this issue which ultimately came down to a question of Respondent's credibility. Two of the committee members were convinced that Respondent had indeed dictated a physical examination and for reasons not of his own making, the dictation was never transcribed into the file. It is noted

that the charge simply calls for the performance of a physical examination and does not ask the committee to comment on quality. Upon consideration of all the above, the committee, by a 2-1 vote finds:

Factual allegation A.1 is **NOT SUSTAINED**

In Allegation A.2, Respondent is alleged to have failed to obtain "indicated psychiatric and neurological consultations." To sustain this charge, the Committee was instructed that first they must find one or both of the examinations were necessitated by the facts and circumstances presented by Patient A and, second, that one or both examinations were not obtained. The Committee finds Respondent did not obtain either examination and that both were warranted by the condition of the patient.

In so finding, the Committee agrees with the State's expert witness and gives his testimony greater weight than the testimony of Respondent and his experts. Dr. Chester, the State's expert, spoke directly and without equivocation. He stated that based on the known psychiatric history of this patient, a psychiatric consultation was warranted (see Tr. 16f.). Respondent testified that he had spoken with Dr. Sanchez, Patient A's psychiatrist, by telephone, on more than one occasion. Dr. Sanchez practiced at the Veteran's Administration hospital and did not have staff privileges at Respondent's hospital. Thus, Dr.

Sanchez would have been ineligible to examine patient A while he was under Respondent's care. Moreover, Respondent's position was that the telephone conversations between himself and Dr. Sanchez, while "informal consultations", were sufficient to meet Respondent's responsibility in this regard. When asked to comment on the efficacy of Respondent's position, Respondent's expert witness, Dr. Pillai, seemed to be equivocal in his testimony. While admitting that there were no notes in the chart summarizing the conversation between Respondent and Patient A's treating psychiatrist, Dr. Sanchez, Dr. Pillai "assumed" pertinent information was discussed between Respondent and Dr. Sanchez (Tr. 572). Dr. Pillai never actually endorsed Respondent's position. After analyzing and synthesizing the testimony and evidence, the Committee concludes that Respondent did indeed contact Dr. Sanchez by telephone and that such conversations were relevant. However, the Committee does not believe that the kind of informal contact indicated by the evidence herein was a substitute for a formal consultation. The Committee agrees with Dr. Chester, the more credible of the two expert witnesses, that a formal psychiatric consultation was warranted under the facts and circumstances of this case. Accordingly, the committee finds:

Allegation A.2 is SUSTAINED

Allegation A.3 alleges Respondent's orders for lithium and librium were "contraindicated". Respondent did not dispute he gave orders for lithium and librium to be administered to this patient. The question presented then, is whether the orders were not medically appropriate. The Committee finds Respondent acted within the bounds of accepted medical practice in regard to the administration of these drugs. In so finding, the Committee considered these factors: Respondent did not fully investigate this patient's neurological status. However, he had blood tests performed which disclosed that the patient's blood lithium level was close to a therapeutic range. He followed-up with further laboratory work and discontinued lithium administration when the level became high. By his failure to perform a neurological work-up, Respondent overlooked possible organic problems in this patient. However, on the whole, the prescribing of the cited substances combined with the laboratory monitoring plus the with follow-up by Respondent was not inappropriate. Therefore, the Committee finds:

Allegation A.3 is NOT SUSTAINED

In Allegation A.4, the State charges that laboratory data showed leukocytosis and anemia in this patient, and that Respondent did not evaluate or treat these conditions. During his testimony, Dr. Chester, the State's expert,

stated that Respondent's care with regard to anemia in this patient was not a deviation from accepted standards of practice (Tr. 62). Therefore the first part of this charge is dismissed on the grounds that the State failed to present a prima facie case.

With regard to the leukocytosis, the Committee does not sustain the charge based upon the following factors: Exhibit 2, page 9, shows two white counts: The first was done at 7:27 A.M. and the second at 10:17 A.M. These show 15.7 and 10.4 respectively. With the 15.7 there were 91% SEG and the second showed 86%. These are clearly abnormal results. That the results exist, demonstrates that Respondent ordered the appropriate tests. Moreover, although Respondent failed to immediately follow-up with appropriate treatment, this was not a deviation from accepted standards. The committee agrees with the State's expert, Dr. Chester, that it was not inappropriate for Respondent to try to obtain a diagnosis, prior to initiating treatment, given the lack of definitive symtomatology (Tr. 56). Under all the facts and circumstances, the committee does not sustain this allegation.

Allegation A.4 is **NOT SUSTAINED**

In allegation A.5, Respondent is charged with the failure to properly evaluate patient A's mental status. He is also charged with the failure to obtain an EEG, a CT

scan of the head and a spinal tap. In reference to the to the three mentioned tests (the EEG, CT scan and spinal tap), the committee dismisses the charge on the grounds that the State's witness Dr. Chester, testified that the failure to obtain such examinations was not a deviation from accepted standards of medicine (Tr. 26, 60).

With regard to the mental status examination, the Committee finds a serious lapse by Respondent. Respondent was willing to accept a psychiatric reason for this patient's problems. This ignored the very real possibility that the problems were organic in nature. A mental status examination was critical to exclude neurological causation in this patient. In the absence of a mental status examination, Respondent was acting in the dark with regard to the very real possibility of organic etiology. Based upon the absence of a formal mental status examination in this patient's record the Committee finds:

Allegation A.5 **is SUSTAINED**

In Allegation A.6, the State alleges that Patient A had a "significant urinary tract infection," and Respondent failed to treat the condition. While it is true that the urinary tract infection was not definitively diagnosed until after this patient expired, the Committee believes the gravamen of this charge was the failure of Respondent to promptly follow up on the leukocytosis and urinanalysis and

urine culture, which would have led to the appropriate diagnosis. Given the severity of the lab reports mentioned under allegation A.4, a urinary tract infection should have been diligently considered and ruled out or treated. Accordingly, the Committee finds:

Allegation A.6 **is SUSTAINED**

In allegation A.7, Respondent is charged with keeping an inadequate medical record for this patient. The Committee sustains this charge based upon these facts: The medical record for this patient, at the time of the hearing, contained no history and no physical examination. Respondent testified that he took a history and performed a physical examination, and dictated his findings into the hospital's electronic dictation system. Respondent stated that he did not know whether the documents were actually transcribed or not and he did not know why the documents were not in the chart. Moreover, Respondent could not explain why the missing documents were not called to his attention by the records department at the hospital, since part of their function is to see that a chart is complete.

The Committee considered Respondent's assertions and ultimately rejected them in finding Respondent culpable for the incomplete nature of the chart. In so finding, it was the Committee's position that the patient was in the hospital long enough that Respondent should have discovered

that these essential items were not present, and either investigated the delay in transcription or re-dictated the documents. Also, it was noted that Respondent signed the final summary on this patient some three months after the patient expired. While the delay in signing the chart is, in itself, neither unusual nor a violation of standards, Respondent had a duty to observe that the essential documents he states he dictated were not in the chart. In addition, the progress notes that do appear in this chart are substandard in that they do not describe the thought process undertaken by Respondent. Any future reviewer, whether a substitute physician or reviewing entity, would have no way of knowing why Respondent selected the various options arrayed before him. Such information is crucial to continuing care or for review after care is given. Based upon the above, the committee finds:

Allegation A.7 is **SUSTAINED**

CONCLUSIONS
REGARDING
SPECIFICATIONS ONE THROUGH FOUR

Having sustained factual allegation A.2, A.5, A.6 and A.7, the Committee turns its attention to the specifications. The question presented is whether any of the factual allegations sustained, constitutes a violation

of the Education Law, as set forth in the charges. More specifically, the State has alleged that the charges under Patient A and Patient B constitute gross negligence and gross incompetence. After careful consideration of both patients (Patient B is discussed infra), the Committee finds no evidence of egregious conduct. While some of Respondent's lapses are serious (as will be developed shortly) they do not rise to the level of either gross negligence or Gross incompetence. Accordingly, the Committee finds:

Specification One **is NOT SUSTAINED**

Specification Two **is NOT SUSTAINED**

Specification Three **is NOT SUSTAINED**

Specification Four **is NOT SUSTAINED**

CONCLUSIONS
WITH REGARD TO
THE FIFTH SPECIFICATION

Under this specification, the committee is asked to consider whether any of the factual allegations sustained with regard to each of the three patients constitutes ordinary negligence. The Committee finds that the facts sustained under allegation A.6 constitute ordinary negligence.

The Committee finds Respondent failed to follow-up, in

a timely fashion, on the white blood count and a urinary analysis. While the white blood count and urinary analysis were ordered in a timely fashion, the results of the urine test were significantly delayed. Given the seriously abnormal nature of the white blood count, the Committee finds that Respondent had a duty to see that the analysis was performed and the results reported to him so that effective and timely action could be taken. The Committee does not find it sufficient that Respondent simply ordered the tests. Accordingly the Committee finds Respondent's failure to follow-up in a timely fashion fell below accepted standards of care and diligence and hence constituted negligence.

The Committee does not find that any of the other allegations sustained under Patient A constitute negligence. Furthermore, this case constitutes only one occasion, therefore the Fifth Specification cannot be sustained at this point.

CONCLUSIONS WITH REGARD TO THE SIXTH SPECIFICATION

Under the Sixth Specification, the Committee is asked whether any of the sustained charges constitute incompetence. The Committee finds that the facts sustained

under allegations A.2 and A.5 constitute incompetence. The essence of the Committee's findings were that Respondent failed to obtain a formal mental status examination of Patient A as well as a neurological examination. Performing one or the other would have confirmed Respondent's apparent finding that the cause of this patient's signs and symptoms were psychiatric in origin. However, without either examination, Respondent ignored the basic and fundamental conclusion that the patient's problems were organic in nature. Thus Respondent acted in the dark and put the patient at risk. This demonstrated a clear lack of knowledge and expertise which fell below accepted standards of medical care. Hence, Respondent is guilty of demonstrating ordinary incompetence in the care of patient A under allegations A.2 and A.5. These allegations constitute one occasion. Therefore the Sixth Specification cannot be sustained at this point.

CONCLUSIONS
WITH REGARD TO
THE SEVENTH SPECIFICATION

The question presented under this specification is whether Respondent's records accurately reflected his evaluation and treatment of this patient, which is the standard created by Section 6530 (32) of the Education Law

and applicable regulations. The Committee was unanimous that for the reasons stated above, in reference to Allegation A.7, Respondent's records constituted a serious departure from accepted standards. As previously mentioned, critical and basic components were missing from the chart. While Respondent stated that he was not at fault for the missing physical examination, the Committee believes that Respondent had ample opportunity to correct the situation but fell short of his duty. Furthermore, the notes that do exist are inadequate in that they do not explain the differential processes that Respondent utilized. Respondent did not disclose his thinking. The failure to provide such disclosure deprived substitute physicians and subsequent reviewers essential information either to continue care or critique performance. The records in question are substandard in that they do not include a clear explanation of the care and treatment rendered by Respondent, including the bases upon which medical options were either taken or rejected. They are thus in violation of Section 6530 (32) of the Education Law. Therefore, the Committee finds:

The Seventh Specification is **SUSTAINED**

FINDINGS OF FACT

WITH REGARD TO

PATIENT B

26. Patient B was treated by Respondent at Central

Suffolk Hospital between January 6, 1990 and January 19, 1990 (Ex. #3, p. 3).

27. Patient B had a history of alcohol abuse which became known to Respondent when he reviewed the records of her prior hospitalizations (374-375; Ex. #3, p. 4A).

28. Respondent first learned about Patient B when he was on call and received a telephone call from an emergency room physician (367-368).

29. Respondent was advised that Patient B was short of breath; that she appeared weak and lethargic; and that she reportedly was on antibiotics on an outpatient basis for presumed bronchitis (368-369).

30. Respondent ordered numerous tests for Patient B including a CBC, SMA-6, SMA-12, PT/PTT, U/A, urine cultures and sensitivity, arterial blood gases, chest x-rays EKG, IV fluids, sputum gram stain and culture and sensitivity, blood culture and sensitivity, IV ampicillin after blood cultures, diet, Tylenol and 50% oxygen by mask (369-372; Ex. #3, p. 39).

31. On January 8 the patients temperature was 102 and 101 on January 10 it was 101.5 and 102.5 (Ex. #3 , P.47A). Patient B spiked a fever of 105 degrees in the afternoon of January 11, 1990 (Ex. #3, p. 47A). Respondent learned about this in the morning on January 12, 1990, when he made his rounds (379; Ex. #3, p. 6A). By that time, the patient's temperature had returned to normal (Ex. #3, p. 6A, 47A).

32. Respondent wrote a note indicating that the antibiotic therapy would be changed and other diagnostic studies would be performed if Patient B spiked another temperature (380; Ex. #3, p. 6A).

33. When Respondent made his rounds in the morning of January 13, 1990, he learned that Patient B had spiked a temperature of 102 degrees the day before (381; Ex. #3, p. 6A, 74A). He changed her antibiotic to Primaxin and he further ordered a repeat urine analysis, repeat urine and blood cultures, a CT scan of the abdomen, an SMA-6, and an SMA-12 (Ex. #3, p. 40A). Respondent was aware that a CVP line was going to be placed and that a routine xDray would then be taken. Accordingly, he did not order a chest x-ray on January 13, 1990, because one would be available the following day (385-386).

34. The chest x-ray of January 14, 1990, revealed that Patient B had a pulmonary process (385-386; Ex. #3, p. 23A).

35. The CT scan of the abdomen came back on January 16, 1990 (388-389); Ex. #3, p. 24). It also revealed a pulmonary process.

36. Respondent investigated Patient B's cardiovascular status early in her hospitalization by ordering her placed on telemetry (376; Ex. #3, p. 39). He did not order Holter monitoring, an echocardiogram or a gated blood pool scan (392-395).

37. Holter monitoring was not available at Central Suffolk Hospital on an in-patient basis (507, 510-511).

38. An echocardiogram and a gated blood pool scan are helpful primarily in investigating the heart's left ventricular function (508-509).

39. All of the blood cultures for Patient B were negative for fungus (395, 619).

40. Patient B had an elevated LDH level (393, 536).

41. Patient B's sputum and urine cultures were positive for yeast (92-93).

CONCLUSIONS WITH REGARD TO PATIENT B

In Allegation B.1, Respondent is cited for allegedly failing to treat patient B's fever in a timely fashion. In Allegation B.2 Respondent is alleged to have failed to properly address this patient's severe pulmonary process. Allegation B.3 alleges Respondent did not obtain repeat x-rays which were medically indicated. The Committee dismisses these charges on the grounds that Dr. Chester, the State's expert, testified that Respondent's actions in these three instances did not represent a departure from accepted standards of medicine (Tr. 105-118). Based upon all of the above, the Committee finds:

Allegation B.1 is DISMISSED

Allegation B.2 is DISMISSED

Allegation B.3 is DISMISSED

In Allegation B.4, Respondent allegedly failed to follow-up on the findings of an abdominal CT scan. The Committee does not sustain this charge. The State was unclear as to what follow-up was necessary. This patient's pneumonia had been documented and was being treated. There was no evidence presented as to what, if anything could have been shown by a repeat of the CT scan. Based upon the evidence presented, the Committee finds:

Allegation B.4 is NOT SUSTAINED

In Allegation B.5, the State alleges Respondent failed to adequately investigate this patient's cardiovascular status by performing diagnostic tests specifically including Holter monitoring, an echocardiogram and a gated blood pool scan. The Committee declines to sustain this charge in consideration of these factors: This patient suffered from alcoholic cardio-myopathy. This condition could not be reversed. Respondent had all the information he needed. Further tests and procedures would not have changed the outcome or management of this case. Therefore they were unnecessary. Accordingly, upon the specific facts of this case, the Committee finds that:

Allegation B.5 is NOT SUSTAINED

Under Allegation B.6 the State alleges Respondent failed to consider HIV disease or Pneumocystis pneumonia in his differential diagnosis. The Committee agrees that a careful review of the patient record discloses that neither diagnosis entered into Respondent's thinking. However, the Committee is also convinced that Pneumosystis pneumonia was sufficiently remote as a possibility that the failure to consider it was not a violation of accepted standards of medicine. Nevertheless, the failure to consider HIV disease was a serious enough lapse to warrant that the charge be sustained. Therefore the Committee finds:

Allegation B.6 is SUSTAINED

Under Allegation B.7, Respondent is cited for a failure to follow-up on an elevated LDH level. While the Committee agrees that the LDH level in this patient showed a massive elevation, the Committee finds Respondent did take appropriate action. The Committee accepts the testimony of Respondent's expert in Cardiology, Dr. Blanco. Dr. Blanco pointed out that the LDH results in this patient had been fractionalized. This allowed Respondent to know the source of the LDH elevation. Dr. Blanco stated that in a critically ill patient like Patient B, such fractionalization went beyond what would be expected of a

prudent practitioner (Tr.537). Thus Respondent did indeed take follow-up action and this went beyond what was merely necessary. Therefore the Committee finds:

Allegation B.7 **is NOT SUSTAINED**

In Allegation B.8, it is alleged Respondent did not follow-up on a finding of yeast organisms. The Committee recognizes that this patient did test positive for yeast in the sputum and urine cultures. However, given the antibiotic treatment the patient was receiving, one would anticipate the natural flora to be disrupted and yeast is to be expected. The treatment for a positive yeast finding of the nature herein is to treat the underlying disease. Respondent was doing this. Therefore the Committee finds:

Allegation B.8 **is NOT SUSTAINED**

Allegation B.9 cites Respondent for maintaining a sub-standard record in this case. The Committee sustains this charge for reasons similar to those under Charge A.7. The Committee finds that the record herein lacks objective facts and evaluation. The facts which were subjective to this patient are also missing. There was no appraisal or plan included. Acceptable records must reflect a practitioner's awareness of a patient's condition. The Committee can find no such notations in Respondent's chart for this patient. Accordingly, the Committee finds:

Allegation B.9 is SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FIRST THROUGH SIXTH SPECIFICATION

As previously stated, the Committee finds no egregious conduct on the part of Respondent. Moreover, while Allegations B.6 and B.9 were sustained, neither will support a finding of negligence or incompetence. The specifications relating to Allegation B.9 do not include negligence or incompetence. As for Allegation B.6, the Committee believes that while the allegation is factually accurate, the treatment complained of simply does not rise to a level of misconduct. While HIV was not investigated, under all the facts and circumstances of this particular patient, the lapse is de minimus. Accordingly, the Committee finds:

Specification Two is **NOT SUSTAINED**

Specification Four is **NOT SUSTAINED**

Specifications Five and Six are not sustained at this time

CONCLUSIONS
WITH REGARD TO
THE EIGHTH SPECIFICATION

The question presented under this specification is

whether Respondent's records accurately reflected his evaluation and treatment of this patient, which is the standard created by Section 6530 (32) of the Education Law and applicable regulations. The Committee was unanimous that for the reasons stated above, in reference to Allegation B.9, Respondent's records constituted a serious departure from accepted standards. As previously mentioned, the notes that Respondent composed are inadequate in that they do not explain the differential processes that Respondent utilized. Respondent did not disclose his thinking. The failure to provide such disclosure deprived substitute physicians and subsequent reviewers essential information either to continue care or critique performance. The records in question are substandard in that they do not include a clear explanation of the care and treatment rendered by Respondent, including the bases upon which medical options were either taken or rejected. They are thus in violation of Section 6530 (32) of the Education Law. Therefore, the Committee finds:

Specification Eight is SUSTAINED

FINDINGS OF FACT
WITH REGARD TO
PATIENT C

42. Respondent first saw Patient C on August 10, 1989, in the emergency room at Central Suffolk Hospital as a

critical care consultant to Dr. Artemio Gregorio, the primary attending physician (432).

43. Patient C had been brought to the hospital by ambulance with a history of nausea, vomiting and diarrhea for five days (433, Ex. #4, p. 2A). She was weak, dehydrated, short of breath and lethargic. She also had a very high blood sugar level (433, Ex. #4, p. 2A).

44. Respondent initially entertained a possible diagnosis of diabetic ketoacidosis (433-434; Ex. #4, p. 7A).

45. Patient C also had a very high and life threatening potassium level of 7 (437-438, Ex. #4, p. 19A).

46. Respondent ordered, inter alia, the administration of intravenous fluids which included dextrose (438-439; Ex. #4, p. 37).

47. Respondent ordered the intravenous administration of insulin to Patient C (438-439; Ex. #4, p. 37).

48. Respondent ordered numerous blood glucose determinations, renal function determinations, electrolytes determinations and arterial blood gas determinations. He also ordered urine levels of ketones but not serum levels of ketones (443-446; Ex. #4, pp. 39-45; Ex. #6).

49. Respondent did not order a ventilation-perfusion lung scan (448-449). A ventilation-perfusion lung scan is performed primarily when pulmonary embolism is suspected (449-450).

50. Respondent ordered that Patient C be admitted to

the intensive care unit (434; Ex. #4, p. 8A). He did not order an echocardiogram or a gated blood pool scan (450-451).

51. Patient C developed hypotension on August 15, 1989 (451). Respondent discussed this with Dr. Gregorio, the primary attending, and recommended that a cardiology consult be called (452-453).

52. Consulting physicians are not permitted under the hospital by laws at Central Suffolk Hospital to call in other consultants. This is the responsibility of the primary attending physician (452, 642).

53. Respondent ordered a comprehensive chemistry evaluation for Patient C including an SMA-6 and an SMA-12 (455, Ex. 4, p. 37, 39).

CONCLUSIONS
REGARDING
FACTUAL ALLEGATIONS
WITH REGARD TO
PATIENT C

In Factual Allegations C.1, C.2, C.3 and C.4 Respondent is cited for mismanagement of a patient suffering from diabetic ketoacidosis. More specifically, he is charged with ordering dextrose (C.1), administering insulin with dextrose and saline intravenously (C.2), failing to order frequent and serial tests to determine blood glucose, renal function, electrolytes, arterial blood gases and serum

and urine levels of ketones (C.3), and failing to take adequate measures to normalize Patient C's glucose values (C.4). The Committee does not sustain these allegations based upon the testimony of Respondent and the patient record.

It is well recognized that the administration of dextrose, insulin and saline to a patient suspected of diabetic ketoacidosis will eventually regulate the patient's glucose levels while avoiding the potentially life threatening condition of elevated potassium. This is because dextrose serves as a carrier which brings the potassium from one compartment to another. The Committee rejects the contrary testimony of Dr. Chester, the State's expert. Dr. Chester's testimony is simply incorrect and the results shown by this patient, the eventual control of glucose and electrolyte levels, shows this. In addition, the patient record discloses a sufficient number of glucose, electrolyte and blood gas tests. In summation, Respondent acted appropriately to recognize, treat and eventually bring down this patient's glucose levels, while avoiding the known risks. Therefore the Committee finds:

Allegation C.1 is **NOT SUSTAINED.**

Allegation C.2 is **NOT SUSTAINED.**

Allegation C.3 is **NOT SUSTAINED.**

Allegation C.4 is **NOT SUSTAINED.**

Under Allegations C.5 and C.6, Respondent is charged with a failure to consider and investigate differential diagnoses of pulmonary alveolar hypoventilation and pulmonary embolism (C.5) and a failure to order a ventilation- perfusion lung scan (C.6) The Committee agrees that Respondent did not specifically address pulmonary alveolar hypoventilation. However, the real issue is the failure to fully investigate the possibility of a pulmonary embolism, which could be a likely cause for the hypoventilation. As Dr. Chester, the State's expert, stated, "hypoventilation means that the lungs are not being adequately ventilated, and that can be from a variety of different reasons, and {...} pulmonary embolism {...} could be a source of the hypoventilation (Tr 191)." As for the possibility of a pulmonary embolism, the Committee believes that the signs and symptoms displayed by this patient were suggestive of this condition, and that therefore Respondent had a duty to consider it. The position of the Committee in this regard was admitted by Dr. Pillai, one of Respondent's experts, who stated that the patients condition was suggestive of, though not necessarily diagnostic for,pulmonary embolism (Tr. 652). In addition, Dr. Blanco, another of Respondent's experts admitted that this patient had some of the risk factors associated with pulmonary embolism including immobilization in bed, shortness of breath and hypoxia (Tr. 553-4). The record also discloses

that the patient was obese. While Dr. Blanco did not know if this patient was obese, he recognized obesity as a risk factor favoring pulmonary embolism. Respondent testified that he considered pulmonary embolism and ruled it out. The Committee finds it difficult to accept that the condition was ruled out by Respondent when the primary diagnostic test for pulmonary embolism, a ventilation-perfusion lung scan, was not performed. Based upon the above the Committee finds:

Allegation C.5 **is SUSTAINED**

Allegation C.6 **is SUSTAINED**

In Allegation C.7, the State charges Respondent with a failure to adequately evaluate Patient C's cardiovascular status. The State then lists echocardiogram and gated blood pool scan as necessary tests. The State's expert, Dr. Chester, pointed out that this patient had an unstable heart rate and blood pressure (Tr. 192). There was also a history of prior cardiac procedures. While the arrythmias and the other abnormal physical findings demonstrated by this patient could have been a result of low blood oxygen, infection or other metabolic factors, the fact that neither an echocardiogram nor a blood pool scan were done left Respondent without sufficient information about the patient's ventricular function. Thus Respondent was treating this patient in the dark with regard to the

causation of the unstable blood pressure and heart rate. These are serious lapses. Therefore the Committee finds:

Allegation C.7 **is SUSTAINED.**

In Allegation C.8 the State alleges Respondent should have ordered a Swan-Ganz catheter when the patient developed hypotension. The Committee accepts Respondent's assertion that as a consultant in this case he lacked authority to direct such catheterization. The Committee also notes that the patient's primary doctor, Dr. Gregorio arranged for the procedure. Therefore, the Committee finds:

Allegation C.8 **is NOT SUSTAINED.**

Allegation C.9 concerns nursing notes that on three consecutive days reported occult blood in the patient's stools. Respondent is charged with failing to note and follow-up on these findings. While the Committee accepts Respondent's statement that as a consultant he lacked the authority to order procedures, the Committee further finds that Respondent's notes make no mention of this potentially serious problem. Although Dr. Gregorio was this patient's primary care physician and therefore the attending physician of record, Respondent was the physician who was actually managing the care of this patient and who composed the majority of the physician's progress notes. This created in Respondent a duty to record his recognition of the symptoms

reported by the nurses and make arrangements, again recorded in the chart, with the primary care physician, for appropriate follow-up. Because Respondent could not actually order procedures for this patient, his notations, if properly composed, would have satisfied his duty to follow-up in this case. Absent any such writing, the Committee finds:

Allegation C.9 **IS SUSTAINED.**

Allegation C.10 cites Respondent for a failure to order a comprehensive chemistry evaluation. During cross-examination, Dr. Chester, the State's expert witness testified that an SMA 12 was ordered by Respondent. The order by Respondent vitiates the charge. Therefore the Committee finds:

Allegation C.10 **is NOT SUSTAINED.**

Allegation C.11 charges Respondent with a failure to maintain a medical record for this patient which accurately reflects the care, treatment and evaluation process undertaken by Respondent. The Committee sustains this allegation noting two particular faults: Respondent made no mention of the occult blood, brought to his attention by the nurse's notes. In addition, the record contains no complete report of his consultation. Respondent could not explain whether the consultation report had been lost or if he

simply failed to compose one. In either case Respondent was responsible to see that the document found its way to the chart. Therefore the Committee finds:

Allegation C.11 is SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FIFTH SPECIFICATION

The Committee finds that Allegations C.5, C.6, C.7 and C.9 evidence a serious lapse in care and diligence and hence constitute negligence. As was discussed under allegations C.5, C.6, and C.7, this patient came before Respondent with significant cardiac abnormalities and at high risk for a pulmonary embolism. The potential consequences of these signs and symptoms were life threatening. Yet Respondent did not perform relatively simple, non-invasive procedures which would have provided significant and necessary insight into the causes of this patient's condition. Even if Respondent believed he had all the information he needed, prudence dictated that the enumerated tests be performed for the benefit of substitute or successor physicians. In the absence of this consideration, Respondent committed significant lapses in care and diligence. With regard to Allegation C.9, Respondent failed to record his recognition of a potentially

serious problem of which he had notice. In this failure Respondent showed a lapse in the level of attention to significant details, expected of a careful physician. Hence the Committee finds:

The Fifth Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE SIXTH SPECIFICATION

In addition to finding negligence in Respondent's actions in regard to Allegations C.5, C.6 and C.7, the Committee also finds a failure by Respondent to demonstrate that level of expertise expected of a physician in this state. Therefore the Committee finds incompetence as well. In so finding, the Committee considered Respondent's testimony about how he ruled out the pulmonary embolism and evaluated the patient's cardiovascular status. The Committee finds Respondent demonstrated fundamental and basic gaps in knowledge essential to treating patients of this nature. That Respondent, in view of the known history of cardiovascular problems in this patient, failed to investigate pulmonary embolism, is an utter failure of the level of expertise expected of a physician. Accordingly the Committee finds:

The Sixth Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE NINTH SPECIFICATION

The question presented under this specification is whether Respondent's records accurately reflected his evaluation and treatment of this patient, which is the standard created by Section 6530 (32) of the Education Law and applicable regulations. The Committee was unanimous that for the reasons stated above, in reference to Allegation C.11, Respondent's records constituted a serious departure from accepted standards. As previously mentioned, Respondent's consultation report, a critical and basic component of an acceptable medical chart, were missing from the record in question. While Respondent stated that he was not at fault for the missing consultation report, the Committee believes that Respondent had ample opportunity to correct the situation but fell short of his duty. Furthermore, the notes that do exist are inadequate in that they do not mention the occult blood cited by the nurses. Moreover, the chart as written does not explain the differential processes that Respondent utilized. Respondent did not disclose his thinking. The failure to provide such disclosure deprived substitute physicians and subsequent reviewers essential information either to continue care or

critique performance. The records in question are substandard in that they do not include a clear explanation of the care and treatment rendered by Respondent, including the bases upon which medical options were either taken or rejected. They are thus in violation of Section 6530 (32) of the Education Law. Therefore, the Committee finds:

The Ninth Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
PENALTY
AND ORDER

In the Allegations and Specification which have been sustained, the Committee finds a pattern of careless practice, in which initial workups are perfunctory and much too limited. Respondent's lack of attention to the details of the process of care do not show sufficient diligence. The severity of patient illness is not appreciated. These details go to the very heart of medical practice. Still, the Committee was impressed that Respondent desires to appropriately treat his patients. The Committee believes that Respondent shows real potential for positive change and professional growth. That Respondent appears to apply rational and objective judgement, however flawed, is a significant positive sign. The Committee believes that

Respondent is a clear candidate for rehabilitation.

In consideration of all of the above, **IT IS HEREBY ORDERED:**

That Respondent shall be placed on **PROBATION**, the said probation to be subject to the following terms:

1. Respondent may continue his office practice.

3. Respondent shall obtain a practice monitor in each institution in which he practices.
4. Respondent shall obtain additional training as set below;
5. Respondent may be required to visit members of the state board for professional medical conduct;
6. all aspects of the above shall be at Respondent's expense and shall be approved by the director of the state board for professional medical conduct or his or her designee (hereinafter, "the director");

It is further **ORDERED;**

That the said training shall consist of a preceptorship, which will be on a part-time basis, in internal medicine of a duration to be determined by the preceptor with the approval of the director, but in any event of not less than six months nor longer than three and one-half years.

It is further **ORDERED THAT;**

The preceptor, with the approval of the director,

shall decide when Respondent is competent to practice without a monitor. At such time, all restrictions listed in this order shall be lifted.

Dated: Albany, New York
January 5, **1992**

Charlotte S. Buchanan
CHARLOTTE S. BUCHANAN, ESQ.
Chairperson

STEPHEN A. GETTINGER, M.D.
RICHARD N. PIERSON, M.D.

APPENDIX I

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

---X

IN THE MATTER OF MUNEER IMAM, M.D.	:	STATEMENT OF CHARGES

---X

MUNEER IMAM, M.D., the Respondent, was authorized to practice medicine in New York State on July 30, 1984 by the issuance of license number 159557 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period Janaury 1, 1991 through December 31, 1992 at 2 Union Avenue, Center Moriches, N.Y. 11934.

FACTUAL ALLEGATIONS

A. Between on or about July 25, 1989 and on or about July 30, 1989, Respondent treated Patient A at Central Suffolk Hospital, Riverhead, New York (Central Suffolk) for a possible lithium overdose. (All patients are identified in the attached Appendix.)

1. Respondent failed to perform a physical examination of Patient A.

2. Respondent failed to obtain indicated psychiatric and neurological consultations.

3. Respondent's orders for lithium and librium for Patient A were contraindicated.

4. Initial laboratory data showed evidence of leukocytosis and anemia. Respondent failed to evaluate or treat these conditions.

5. Respondent failed to properly evaluate Patient A's mental status. He failed to order an EEG, a CT scan of the head and a spinal tap.

6. Patient A had a significant urinary tract infection. Respondent failed to treat this condition.

7. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient's history and physical examination, rationales for tests and treatment, test results, evaluation of test results, progress notes and discharge summary.

B. Between on or about January 6, 1990 and on or about January 19, 1990, Respondent treated Patient B at Central Suffolk for sepsis.

1. Respondent failed to treat Patient B's fever in a timely fashion. Patient B's temperature spiked to 105 F on January 11, 1990. Respondent improperly waited until January 13, 1990 to change the patient's antibiotic therapy and to order additional cultures and diagnostic studies. He improperly waited until January 14, 1990 to request an infectious disease consultation.

2. Respondent failed to properly appreciate, evaluate and treat Patient B's severe pulmonary process.

3. Respondent failed to obtain indicated repeat chest x-rays between January 6, 1990 and January 13, 1990 and between January 15, 1990 and January 17, 1990.

4. Respondent failed to follow-up the findings of an abdominal CT scan of January 16, 1990 and of a chest x-ray of January 17, 1990.

5. Respondent failed to adequately investigate Patient B's cardiovascular status. He failed to order indicated

heart testing including Holter monitoring, an echocardiogram and a gated blood pool scan.

6. Respondent failed to consider the differential diagnosis of HIV disease with a fungal sepsis or Pneumocystis pneumonia.

7. Patient B had an elevated LDH level. Respondent failed to properly follow-up this finding.

8. Sputum and urine cultures demonstrated yeast organisms. Respondent failed to properly follow-up these findings.

9. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient's history and physical examination, rationales for tests and treatment, test results, evaluation of test results, progress notes and discharge summary.

C. Between on or about August 10, 1989, and on or about August 18, 1989, Respondent treated Patient C at Central Suffolk for severe dehydration and possible diabetic ketoacidosis.

1. On nine occasions Respondent ordered intravenous fluids containing dextrose. These orders were contraindicated in a patient with suspected diabetic ketoacidosis.

2. Respondent administered insulin to Patient C in combination with dextrose and saline in an intravenous solution. This was not indicated.

3. Respondent failed to order frequent and serial determinations of blood glucose, renal function, electrolytes, arterial blood gases and serum and urine levels of ketones.

4. Respondent failed to take adequate measures to normalize Patient C's glucose values.

5. Respondent failed to consider and investigate differential diagnoses of pulmonary alveolar hypoventilation and a pulmonary embolism.

6. Respondent failed to order a ventilation - perfusion lung scan.

7. Respondent failed to adequately evaluate Patient C's cardiovascular status by his failure to order an echocardiogram and a gated blood pool scan.

8. On August 15, 1989, Patient C developed hypotension. Respondent failed at that time to order the insertion of an arterial line and a Swan - Ganz catheter.

9. On three consecutive days nurses noted stools that were positive for occult blood. Respondent failed to note or follow-up this finding with appropriate diagnostic tests including examination of gastric aspirate, gastroscopy, X-rays, sonography and a CT scan.

10. Respondent failed to order a comprehensive chemistry evaluation including liver function tests, serum protein, serum amylase and lipose and urinary electrolytes.

11. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient's history and physical examination, rationales for tests and treatment, test results, evaluation of test results and a complete report of consulation.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

1. The facts contained in paragraphs A and A.1 through A.6.

2. The facts contained in paragraphs B and B.1 through B.8.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1992), in that Petitioner charges:

3. The facts contained in paragraphs A and A.1 through A.6.

4. The facts contained in paragraphs B and B.1 through B.8.

FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

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

5. The facts contained in Paragraphs A and A.1-A.6, B and B.1-B.8, and/or C and C.1-C.10.

SIXTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

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

6. The facts contained in paragraphs A and A.1-A.6, B and B.1-B.8, and/or C and C.1-C.10.

SEVENTH THROUGH NINTH SPECIFICATIONS

FAILURE TO MAINTAIN ADEQUATE RECORDS

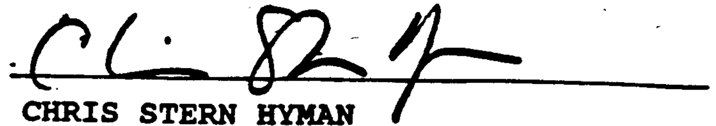
Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1992), in that he failed to maintain records for patients which accurately reflected his evaluation and treatment of the patients. Petitioner charges:

7. The facts contained in paragraphs A and A.7.

8. The facts contained in paragraphs B and B.9.

9. The facts contained in paragraphs C and C.11

DATED: New York, New York
July 2, 1992



CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct