STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

July 28, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Farhang Bakhtiar, M.D.
8 Pine Drive
Woodbury, New York 11797

David W. Smith, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

RE: In the Matter of Farhang Bakhtiar, M.D.

Effective Date: 08/04/95

Dear Dr. Bakhtiar and Mr. Smith:

Enclosed please find the Determination and Order (No. 95-158) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Request for review of the Committee's determination by the Administrative Review Board stays 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
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

FARHANG BAKHTIAR, M.D.

DETERMINATION

AND

ORDER

BENJAMIN WAINFELD, M.D., Chairperson, DANIEL A. SHERBER, M.D. and **KENNETH KOWALD**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230(1) of the Public Health Law, served as Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **JANE B. LEVIN, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	March 30, 1995
Hearing date:	June 7, 1995
Deliberation date:	July 12, 1995
Place of hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001

Petitioner appeared by:

Jerome Jasinski, Esq.
Acting General Counsel
NYS Department of Health
BY: David W. Smith, Esq.
Associate Counsel

Respondent did not appear.

WITNESSES

For the Petitioner: Howard Chester, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence on more than one occasion, failed to maintain adequate records, and ordered excessive tests for patients. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers of exhibits. These citations 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.

GENERAL FINDINGS

1. Farhang Bakhtiar, M.D., the Respondent, is a physician duly license to practice medicine in New York State, but he is not currently registered with the New York State Education Department. (Pet. Ex. 2)

2. Respondent no longer resides in the United States, but has abandoned his family and returned to Iran. (Pet. Ex. 3)

3. Respondent was served pursuant to New York Public Health Law Section 230(10)(d). (Pet. Exs. 1, 3)

FINDINGS OF FACT AS TO PATIENT A

4. Respondent treated Patient A in August and September, 1992. (Tr. 12-13; Pet. Ex. 4)

5. Respondent performed an adequate physical examination and obtained an adequate medical history. (Pet. Ex. 4)

6. Respondent performed a pulmonary function test on Patient A, which was not medically indicated and was not correctly performed. (Tr. 14-15; Pet. Ex. 4)

7. Patient A complained of both chest pain and bronchitis, but Respondent did not follow-up or treat these complaints. (Tr. 14-16, 18; Pet. Ex. 4)

8. Respondent did not treat Patient A's chronic alcoholism or counsel her or refer her for specialized treatment. (Tr. 15-16; Pet. Ex. 4)

9. The patient record for Patient A does not accurately reflect the evaluation and treatment of Patient A. (Tr. 67-69; Pet. Ex. 4)

CONCLUSIONS AS TO PATIENT A

- Respondent inappropriately and incorrectly performed a pulmonary function test on Patient A. This constituted a deviation from acceptable medical standards.

- The care rendered to Patient A by Respondent did not meet minimum acceptable medical standards, since he failed to treat Patient A's chest pain and bronchitis, and failed to treat Patient A's alcoholism or refer her for specialized treatment.

- Respondent also failed to maintain a record which accurately reflected his evaluation and treatment of Patient A.

FINDINGS OF FACT AS TO PATIENT B

10. Respondent treated Patient B in July and September, 1992. (Tr. 43; Pet. Ex. 5)

11. Respondent performed an adequate physical examination and obtained an adequate medical history. (Pet. Ex. 5)

12. Respondent performed a stress test on Patient B for which there was no medical necessity. (Tr. 46; Pet. Ex. 5)

13. Respondent performed two (2) pulmonary function tests on Patient B, neither of which were medically justified, and both of which were incorrectly administered. (Tr. 46; Pet. Ex. 5)

14. Patient B complained of stomach pain and body ache, but Respondent failed to follow-up or treat these complaints. (Tr. 47; Pet. Ex. 5)

15. Patient B was a chronic alcoholic, but Respondent failed to treat, counsel or refer him for treatment. (Tr. 44; Pet. Ex. 5)

16. The patient records for Patient B did not accurately reflect the evaluation and treatment of Patient B. (Tr. 67-68; Pet. Ex. 5)

CONCLUSIONS AS TO PATIENT B

- Respondent inappropriately and incorrectly performed stress and pulmonary function tests on Patient B. This constituted a deviation from acceptable medical standards.

- The care rendered to Patient B by Respondent did not meet minimum acceptable medical standards, since he failed to treat Patient B's stomach pain and body ache and failed to treat Patient B's alcoholism or refer him for specialized treatment.

- Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient B.

FINDINGS OF FACT AS TO PATIENT C

17. Respondent treated Patient C in September and October, 1992. (Tr. 26-28; Pet. Ex. 6)

18. Respondent performed an adequate physical examination and obtained an adequate medical history. (Pet. Ex. 6)

19. Patient C complained of chest pain, but Respondent failed to follow-up or treat such condition. (Tr. 32, 41; Pet. Ex. 6)

20. Respondent gave Patient C a stress test and two (2) pulmonary function tests, none of which were medically justified. (Tr. 32-34; Pet. Ex. 6)

21. The two (2) pulmonary function tests were incorrectly administered. (Tr. 33; Pet. Ex. 6)

22. Patient C was a chronic alcoholic. Nevertheless, Respondent failed to treat, counsel, or refer him for treatment. (Tr. 35; Pet. Ex. 6)

23. The patient record for Patient C does not accurately reflect the evaluation and treatment of Patient C. (Tr. 67-68; Pet. Ex. 6)

CONCLUSIONS AS TO PATIENT C

- Respondent inappropriately and incorrectly performed stress and pulmonary function tests on Patient C. This constituted a deviation from acceptable medical standards.

- The care rendered to Patient C by Respondent did not meet minimum acceptable medical standards, since he failed to treat Patient C's chest pain and failed to treat Patient C's alcoholism or refer him for specialized treatment.

- Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient C.

FINDINGS OF FACT AS TO PATIENT D

24. Respondent treated Patient D in September and October, 1992. (Tr. 51-51; Pet. Ex. 7)

25. Respondent performed an adequate physical examination and obtained an adequate medical history. (Pet. Ex. 7)

26. Respondent performed an electrocardiogram on Patient C which showed abnormal results. Respondent failed to follow-up or treat this condition. (Tr. 53-54; Pet. Ex. 7)

27. Respondent performed a stress test and two (2) pulmonary function tests on Patient D which were not medically justified. (Tr. 54-55; Pet. Ex. 7)

28. The pulmonary function tests were not correctly administered. (Tr. 55; Pet. Ex. 7)

29. The patient record for Patient D does not accurately reflect the evaluation and treatment of Patient D. (Tr. 67-69; Pet. Ex. 7)

CONCLUSIONS AS TO PATIENT D

- Respondent inappropriately and incorrectly performed stress and pulmonary function tests on Patient D. This constituted a deviation from acceptable medical standards.

- The care rendered to Patient D by Respondent did not meet minimum acceptable medical standards, since he failed to follow-up and treat an abnormal electrocardiogram.

- Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient D.

FINDINGS OF FACT AS TO PATIENT E

30. Respondent treated Patient E in September and October, 1992. (Tr. 58; Pet. Ex. 8)

31. Respondent performed an adequate physical examination and obtained an adequate medical history. (Tr. 61; Pet. Ex. 8)

32. Respondent prescribed Feldene for Patient E which was not medically indicated. (Tr. 61; Pet. Ex. 8)

33. Respondent performed a stress test and two (2) pulmonary function tests on Patient E, which were not medically necessary. (Tr. 61-62; Pet. Ex. 8)

34. The two (2) pulmonary function tests were not correctly administered. (Tr. 51-62; Pet. Ex. 8)

35. Respondent diagnosed Patient E with a rash but failed to follow-up or treat such condition. (Tr. 61-62; Pet. Ex. 8)

36. The patient record for Patient E does not accurately reflect the evaluation and treatment of Patient E. (Tr. 61-62; Pet. Ex. 8)

CONCLUSIONS AS TO PATIENT E

- Respondent inappropriately and incorrectly performed stress and pulmonary function tests on Patient E. This constituted a deviation from acceptable medical standards.

- The care rendered to Patient E by Respondent did not meet minimum acceptable medical standards, since he failed to follow-up and treat Patient E's rash, and inappropriately prescribed medication.

- Respondent failed to maintain a record which accurately reflected his evaluation and treatment of Patient E.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Practicing with negligence on more than one occasion)

SUSTAINED as to Paragraphs A and A3, 4, 5, 6; B and B3, 4, 5, 6; C and C3, 4, 5, 6; D and D3, 4, 5, 6; E as to dates and place of treatment only and E3, 4, 5, 6.

SECOND THROUGH SIXTH SPECIFICATIONS:
(Failing to maintain an adequate record)

SUSTAINED as to A and A5, 6; B and B5, 6; C and C3, 5, 6; D and D3, 6; E as to dates and place of treatment only and E5.

NOT SUSTAINED as to Paragraphs A1, 2; B1, 2; C1, 2; D1, 2; E as to dates and place of treatment only and E1, 2.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS:
(Excessive testing)

SUSTAINED as to Paragraphs A and A3, 4; B and B3, 4; C and C4, 5; D and D4, 5; E as to dates and place of treatment only and E3, 4.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Respondent failed to appear personally or by counsel. However, the Hearing Committee found Petitioner's expert witness to be highly credible and agreed that the quality of medical care provided for all patients was grossly inadequate, with failure to evaluate patients' complaints, and failure to follow-up these complaints with appropriate laboratory tests, evaluation and treatment.

In addition the Respondent performed pulmonary function and stress tests entirely without any medical justification. The pulmonary function tests, in particular, could not have been performed correctly, based upon the impossible results documented in the charts. The stress tests are also questionable, because there was never a mention in the patient charts of the protocols used and there is no record of ECGs performed during the exercise tests. Further, there were no interpretations noted of the ECG's that were performed.

The Hearing Committee finds it most egregious that there were no appropriate referrals for counseling and/or treatment of the patients whose history indicated chronic alcoholism or other substance abuse.

Under these circumstances, the Hearing Committee has no other option but to revoke the Respondent's license.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

Dated: July 27 **New York, New York**
, 1995

BENJAMIN WAINFELD, M.D.
Chairperson

DANIEL A. SHERBER, M.D.
KENNETH KOWALD

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

IN THE MATTER

OF

FARHANG BAKHTIAR, M.D.

NOTICE

OF

HEARING

TO: FARHANG BAKHTIAR, M.D.
8 Pine Drive
Woodbury, New York 11797

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on 7th day of June, 1995, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the

Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO

REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 30, 1995

Chris Stern Hyman
Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: David W. Smith
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2617

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

IN THE MATTER

OF

FARHANG BAKHTIAR, M.D.

STATEMENT

OF

CHARGES

FARHANG BAKHTIAR, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 26, 1970, by the issuance of license number 105556 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. From in or about August, 1992 through in or about October, 1992, Respondent treated Patient A, a chronic alcoholic, for stomach pains and other medical conditions at his office at 222 East 116th Street, New York City. (Patients are identified in the Appendix hereto.)

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Respondent performed a "stress test" on Patient A which was inappropriate.

4. Respondent performed a pulmonary function test on Patient A which was inappropriate and which was performed incorrectly.

5. Patient A complained of chest pain but Respondent failed to follow-up or treat it or note such follow-up or treatment, if any.

6. Patient A complained of bronchitis but Respondent failed to follow-up or treat it, or note such follow-up or treatment, if any.

7. Despite the fact that Patient A was a chronic alcoholic, Respondent failed to refer her to specialized treatment or note such referral, if any.

B. Between in or about July, 1992 and September, 1992, Respondent treated Patient B, a chronic alcoholic, for hypertension and other medical conditions at his office at 222 East 116th Street, New York City.

1. Respondent failed to perform an adequate physical examination on Patient B, or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Respondent performed a stress test which was inappropriate.

4. Respondent gave Patient B two pulmonary function tests which

were inappropriate and administered them improperly.

5. Patient B complained of stomach pains and body ache but Respondent failed to follow-up or treat them or note such follow-up or treatment, if any.

6. Despite the fact that Patient B was a chronic alcoholic, Respondent failed to refer him for specialized treatment or note such referral, if any.

C. During in or about September, 1992 and October, 1992, Respondent treated Patient C, a chronic alcoholic, for stomach pains and other medical conditions at his office at 222 East 116th Street, New York City.

1. Respondent failed to perform an adequate physical examination on Patient C, or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Patient C complained of chest pains but Respondent failed to follow-up or treat such condition or note such follow-up, if any.

4. Respondent gave Patient C a stress test which was inappropriate.

5. Respondent gave Patient C two pulmonary function tests which

were inappropriate and administered improperly.

6. Despite the fact that Respondent knew Patient C was a chronic alcoholic and substance abuser, Respondent failed to refer Patient C for specialized care or note such referral, if any.

D. During in or about September, 1992 and October, 1992, Respondent treated Patient D, a chronic alcoholic and former substance abuser, for stomach pains and other medical conditions at his office at 222 East 116th Street, New York City.

1. Respondent failed to perform an adequate physical examination on Patient D or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Respondent gave Patient D a resting electrocardiogram which showed markedly abnormal results. Respondent failed to follow-up or treat such abnormality or note such follow-up, if any.

4. Respondent performed a stress test on Patient D which was inappropriate.

5. Respondent administered two pulmonary function tests to Patient D which were inappropriate and administered improperly.

6. Despite the fact that Patient D was a chronic alcoholic, Respondent failed to refer him for specialized care or note such referral, if any.

E. During in or about September, 1992 and October, 1992, Respondent treated Patient E, a chronic alcoholic and former substance abuser, for stomach pains and other medical conditions at his office at 222 East 116th Street, New York City.

1. Respondent failed to perform an adequate physical examination on Patient D, or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Respondent prescribed Feldene for Patient E's "low back arthalgia" which was inappropriate.

4. Respondent conducted a stress test on Patient E which was inappropriate.

5. Respondent noted that Patient E had a rash, but failed to follow-up or treat it or note such follow-up treatment, if any

6. Respondent performed two pulmonary function tests on Patient E which were inappropriate and improperly administered.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1995) by practicing the profession of medicine with negligence on more than one occasion in that Petitioner charges two or more of the following:

1. Paragraphs A and A3, 4, 5, 6; B and B3, 4, 5, 6; C and C3, 4, 5, 6; D and D3, 4, 5, 6; and/or E and E3, 4, 5, 6.

SECOND THROUGH SIXTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law §6530(32)(McKinney Supp. 1995). Specifically, Petitioner charges:

2. The facts in Paragraphs A and A1, 2, 5, 6.
3. The facts in Paragraphs B and B1, 2, 5, 6.
4. The facts in Paragraphs C and C1, 2, 3, 6.
5. The facts in Paragraphs D and D1, 2, 3, 6.
6. The facts in Paragraphs E and E1, 2, 5,

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

EXCESSIVE TESTING

Respondent is charged with the ordering of excessive tests not warranted by the condition of the patient within the meaning of N.Y. Educ. Law §6530(35)(McKinney Supp. 1995). Specifically, Petitioner charges:

7. The facts in Paragraphs A and A3, 4.
8. The facts in Paragraphs B and B3, 4.
9. The facts in Paragraphs C and C4, 5.
10. The facts in Paragraphs D and D4, 5.
11. The facts in Paragraphs E and E3, 4.

DATED: March 30, 1995
New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct