STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 4, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Gayle, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza – 6th Floor
New York, New York 10001

Barry M. Fallick, Esq.
Rochman, Platzer, Fallick &
Sternheim, LLP
666 Third Avenue
New York, New York 10017

Swapnadip Lahiri, M.D.
52 Delford Avenue
Oradell, New Jersey 07649

RE: In the Matter of Swapnadip Lahiri, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-141) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), 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.

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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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:cah
Enclosure

COPY

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

IN THE MATTER OF SWAPNADIP LAHIRI, M.D.	DETERMINATION AND ORDER BPMC 00-141

DANIEL W. MORRISSEY, O.P., Chairperson, **RUFUS NICHOLS, M.D.** and **ALVIN RUDORFER, M.D.**, 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 Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG**, General Counsel, **ANNE GAYLE, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared by **ROCHMAN, PLATZER, FALLICK, & STERNHEIM, ESQS., BARRY M. FALLICK, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged twelve (12) specifications of professional misconduct, including allegations of negligence, fraudulent practice, willfully harassing, abusing and

intimidating a patient, moral unfitness and failure to maintain records. The charges are more specifically set forth in the Statement of Charges dated October 29, 1999, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

WITNESSES

For the Petitioner: Patient A
Valery F. Lanyi, M.D.
Robert Shimm, M.D.

For the Respondent: None

FINDINGS OF FACT

1. Swapnadip Lahiri, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20, 1993, by the issuance of license number 193715, by the New York State Education Department. (Dept.'s Ex. 2)

2. Respondent treated Patient A, a then 26-year-old female, at Respondent's office which was located at North Bronx Medical, P.C., 799 Morris Park Avenue, Bronx, New York, for a work-related injury, from approximately March 8, 1996 to July 12, 1996. (Dept.'s Ex. 3, 4, 5, 6, 7, Resp.'s Ex. C) (T1, p. 19-20)

3. Patient A saw Respondent at the aforesaid office on Fridays; some of the approximately 11 visits were scheduled in advance and some came about when Respondent asked Patient A to step into his office when she was at the facility to receive physical therapy. Respondent did not note each visit with Patient A in her chart. (Dept.'s Ex. 3, 4, 5, 6, 7, Resp.'s Ex. C) (T1, p. 22-25)

4. When Patient A was seen by C. M. Sharma, M.D., a Neurologist, on May 1, 1996, she complained of urinary frequency; he instructed her to report the urinary frequency to her treating physician. Patient A complained of urinary frequency to Respondent on May 10, 1996 and again on May 17, 1996, at which time Respondent informed her that he had to examine her bladder before he could give her medication. On May 24, 1996, Respondent performed a pelvic examination on Patient A, and told her that he still could not give her medication. He then ordered urine, blood and stool tests. (Dept.'s Ex. 3, 4, 5, 6, 7, Res.'s Ex. C) (T1, p. 26-32)

5. Respondent provided the Department with two sets of records which he certified to be complete, true and exact copies of his records regarding Patient A (Dept.'s Ex. 3 and 4); Respondent also provided Workers' Compensation Board (WCB) with a copy of his records regarding Patient A (Dept.'s Ex. 5). The record, which Respondent provided to WCB, does not show a complaint of frequency of urination and/or an impression of rule out urinary tract infection on March 8, 1996. (Dept.'s Ex. 3, p. 2-3, Ex. 4, p. 3-4, Ex. 5, p. 21-22) (T1, p. 145-148, T2, p. 11-12)

6. Exhibit 4 was dated September 3, 1996; Exhibit 3 was dated February 28, 1997. The entries for Patient A's April 5, 1996 visit on page 5 of Exhibit 4 and page 4 of Exhibit 3 differ in that under the heading "Still complaints of" " 4 Frequency of urination" is darker on page 4 of Exhibit 3 (the later version) than it is on page 5 of Exhibit 4, and there are two question marks in this entry on page 4 of Exhibit 3 (the later version) but no question marks in this entry on page 5 of Exhibit 4. There is also an entry for an April 26, 1996 visit on page 6 of Exhibit 3 but there is no entry for a visit for that date in Exhibit 4. (Dept.'s Ex. 3 and 4) (T2, p. 11-14)

7. Respondent's records show that Patient A complained of urinary frequency on March 8, 1996 and April 5, 1996 and that she complained of urinary incontinence on April 26, 1996. Respondent ordered a urinalysis and/or culture on May 24, 1996. (Dept.'s Ex. 3, 4, 5, 6, 7, Res.'s Ex. C) (T1, p. 26-27, 31,145-149)

8. Respondent performed a pelvic examination upon Patient A on either April 26, 1996, or May 24, 1996. (Dept.'s Ex. 3, 6, 7, Res.'s Ex. C, T1, p.26-28)

9. On or about May 28, 1996, Respondent called Patient A and asked her for a date for lunch in a restaurant that was in a hotel. She refused. When Patient A called Respondent back, she taped their conversation. (Dept.'s Ex. 8, 9, 10, 11, 12) (T1, p. 33-35)

10. On or about June 28, 1996, Respondent again asked Patient A for a date, specifically he asked her to go to a movie. (T1, p. 44-46,)

11. Throughout the course of treatment, Respondent made inappropriate verbal comments to Patient A. Respondent told Patient A that she was pretty, she had a nice body, she should model, he could help her get into modeling, he knew someone who could take pictures of her. (T1, p. 32-33)

12. Patient A's last office visit with Respondent was on June 28, 1996. Patient A went to Respondent's office on July 12, 1996 to request a doctor's note and a referral from Respondent, but Respondent informed her that he was no longer her physician, and an argument ensued. When Patient A left Respondent's office, she went immediately to the Human Rights Commission to file a complaint against Respondent. Patient A subsequently filed a written complaint with OPMC on July 23, 1996, and OPMC requested Patient A's records on August 6, 1996. (Res.'s Ex. D) (T1, p. 46-49, T2, p. 19-20)

13. On or about June 5, 1997, Respondent, in an interview with OPMC, denied asking Patient A for a date. (T2, p. 14-15, 21-22)

14. Respondent altered his record regarding Patient A's March 8, 1996 visit with him by adding to the patient's complaints: " 4 Frequency of urination", and by adding to his impression " 4 R/O UTI". (Ex.3, p.2-3)

15. At an interview with OPMC, on June 5, 1997, when questioned about the changes in the records, Respondent denied that he was the one who altered the records. Respondent submitted the aforesaid altered record to OPMC. (Dept.'s Ex. 3, 4, 5) (T1, p. 145-148, T2, p. 14, 21-22)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2)
Paragraph A.1:	(4)
Paragraph A.2:	Not Sustained
Paragraph A.2(a):	Not Sustained
Paragraph A.3(a):	(9)
Paragraph A.3(b)	(10)
Paragraph A.3(c)	(11)
Paragraph B	(13)
Paragraph C	(14)
Paragraph D	(15)
Paragraph E	(3-7, 14)

The Hearing Committee further concluded that the following Specifications are sustained. The citations in parenthesis refer to the Factual Allegations which support each Specification:

FRAUDULENT PRACTICE

Paragraph A: NOT SUSTAINED (Vote 2-1)

Paragraph B

Paragraph C

Paragraph D

NEGLIGENCE ON MORE THAN ONE OCCASION

NOT SUSTAINED

WILLFULLY HARASSING, ABUSING AND INTIMIDATING A PATIENT

NOT SUSTAINED (Vote 2-1)

MORAL UNFITNESS

Paragraph A: NOT SUSTAINED (Vote 2-1)

Paragraph B

Paragraph C

Paragraph D

Paragraph E

FAILURE TO MAINTAIN RECORDS

Paragraph E

The Hearing Committee further concluded that the following specifications should not be sustained:

First Specification

Fifth Specification

Sixth Specification

Seventh Specification

DISCUSSION

Respondent is charged with twelve (12) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that eight (8) of the twelve (12) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the

credibility of the witnesses presented by the parties. The Department called Patient A, Dr. Valery Lanyi and Dr. Robert Shimm as witnesses. The Hearing Committee found Patient A to be credible despite some inconsistencies. The Hearing Committee believes that Patient A taped her conversation with Respondent at the prompting of a third party. (T1, 34-35,42-43,72-74,98-100) This assumption however, does not nullify the nature of this charge against Respondent. The Hearing Committee notes that Petitioner did not call Patient A's mother, although Patient A testified that her mother had been present during the pelvic exam as well as several of the office visits. (T1,28, 30,48,56-57) The Hearing Committee further notes that Respondent did not refute the testimony of Patient A.

The Department called Dr. Valery F. Lanyi as an expert witness. Dr. Lanyi is a professor of rehabilitation medicine a NYU Medical Center in the Department of Rehabilitation Medicine at the Rusk Institute. (T1, 137) She is board certified in rehabilitation medicine. (T1, 139) The Hearing Committee found her to be qualified as well as credible, but note that she is not an expert in the practice of urology or gynecology. The Hearing Committee further notes that Respondent did not call an expert witness to refute the testimony of Dr. Lanyi.

The Department also called Robert Shimm, M.D. , a medical coordinator for the Office of Professional Medical Conduct to testify about his interview with Respondent. Dr. Shimm testified specifically that Respondent had emphatically denied that he had asked Patient A out for a date. (T2, 14-15) Dr. Shimm further testified that Respondent acknowledged that the inconsistencies regarding Patient A's complaints of frequency of urination and the impression of "4R/O UTI were an alteration of the patient's records but denied that he had written these notes. (T2, 12-14) The Hearing Committee finds Dr. Shimm to be an unbiased witness. No motive for falsification or fabrication of his testimony was alleged or proven and Respondent did not refute his testimony. The Hearing Committee, therefore, gave great weight to Dr. Shimm's testimony.

The Respondent did not take the stand and he offered no witnesses on his behalf. Respondent was instructed that the Hearing Committee could draw a negative inference from his failure to

testify. (T 2. p. 24) The Hearing Committee was instructed that they could draw a negative inference from Respondent's failure to testify as established by law. Baxter v. Palmigiano, 425 U.S. 308 (1976), Matter of Germaine B., 447 N.Y.S.2d 448, App. Div. 1st Dept. (1982), DeBonis v. Corbisiero, 547 N.Y.S.2d 274, App.Div.2d Dept. (1989) Respondent acknowledged that he understood the instruction. (T2. pp.24-25) The Hearing Committee elected to draw a negative inference in this instance. They note that this was not their sole consideration in making their determination, but that they relied upon all of the credible evidence offered. Therefore, the Hearing Committee finds that the testimony of Patient A, Dr. Lanyi and Dr. Shimm stands unrefuted.

FRAUDULENT PRACTICE

Charge A2 and A2(a) allege that Respondent performed an unwarranted and unnecessary pelvic exam during which he inappropriately touched Patient A. With respect to Charge A2 and A2(a), the majority of the Hearing Committee was not persuaded by the testimony of Patient A that Respondent inappropriately examined her. (T1, 28-30, 79, 82-83) Furthermore, Dr. Lanyi's testimony did not persuade the majority that the pelvic examination was inappropriate. (T1. 155-161) The majority of the Hearing Committee finds that the pelvic exam was within the standard of care of acceptable medical practice. Therefore, these charges are not sustained by a vote of 2 to 1.

Charge B alleges that on or about June 5, 1997, Respondent, in an interview with OPMC, knowingly and intentionally falsely denied asking Patient A for a date. The Hearing Committee infers from the testimony of Patient A and Dr. Shimm, as well as the taped conversation between Patient A and Respondent (Ex. 8) that Respondent did indeed ask Patient A for a date and then intentionally lied about it during his interview with OPMC. Therefore, the Hearing Committee sustains this charge.

Charge C alleges that Respondent, with intent to deceive, knowingly and intentionally falsely altered his record regarding Patient A's March 8, 1996 visit with him by adding to the patient's complaints"4 Frequency of urination", and by adding to his impression "4 R/O UTI." Upon

examination of the record, the Hearing Committee finds that it was in fact altered and they believe it was altered by Respondent to protect himself against disciplinary action. Therefore, the Hearing Committee sustains this charge.

Charge D alleges that Respondent knowingly and intentionally falsely created and/or submitted the aforesaid altered record to OPMC with the intention of deceiving OPMC when OPMC requested said records while Respondent was under investigation by OPMC. Pursuant to the altered state of the records submitted and the testimony of Dr. Shimm, the Hearing Committee finds that Respondent acted fraudulently in this instance. As a result the Second, Third and Fourth Specifications are sustained.

NEGLIGENCE ON MORE THAN ONE OCCASION

Charge A and A.1 allege that Respondent failed to timely perform a necessary urine analysis upon Patient A. Patient A testified that she told Respondent about the frequency of urination problem about 2 weeks before he performed the pelvic exam. (T1. 26-32) Dr. Lanyi stated that "a urinalysis and urine culture should have still been the first avenue to explore" and that it was below the standard of care to do the pelvic examination before these tests were ordered. (T1. 150-152) The Hearing Committee concurs with Dr. Lanyi's opinion and finds that Respondent was negligent for his failure to timely order the urine analysis. For reasons previously discussed, the majority of the Hearing Committee found that the pelvic exam did not fall below the standard of care. The Hearing Committee further finds that the acts enumerated in Paragraphs C and E were intentional acts and not ones of omission, therefore they do not meet the definition of negligence. Since only one act of negligence has been sustained, the Hearing Committee cannot sustain the Fifth Specification as negligence on more than one occasion.

WILFULLY HARASSING, ABUSING AND INTIMIDATING A PATIENT

The Hearing Committee, by majority opinion, has previously discussed why it has not

sustained the charges in Paragraphs A2 and A2(a) regarding an inappropriate, unwarranted pelvic exam. It is further alleged in Paragraph A3(a), (b) and (c) that Respondent's repeatedly asking Patient A out for a date and other inappropriate verbal comments made to her constitute willful harassment, abuse or intimidation of Patient A. Upon review of the testimony of Patient A and her taped conversation with Respondent (Exs. 8 and 11) , the Hearing Committee finds that Respondent did harass Patient A on several occasions in asking for a date and by making some inappropriate comments to her. They note that even Respondent's attorney in his opening statement acknowledged that Respondent's "conduct in asking the patient to go to lunch and the movies was foolish, in poor judgment but not related to his role as a physician." (T1., p. 14) Although the Hearing Committee unanimously found this conduct to be inappropriate, the majority of the Hearing Committee found that these actions did not rise to the level of willful harassment under § 6530(1) of the Education Law. The Hearing Committee also reviewed the New York State Board for Professional Medical Conduct Policy Statement on Physician Sexual Misconduct. (Page 118 Board Manual) The majority found that Respondent's actions did not rise to the level of willful harassment under this policy because they found no evidence that Respondent was soliciting a sexual relationship. The majority finds that Respondent's actions were socially inappropriate for crossing the boundary line between the physician and patient, but they do not find that Respondent's actions rose to the level of a willful harassment. They further find that Respondent ceased inviting Patient A out after several attempts and there is no evidence of any retaliatory abuse or intimidation in the record. They note that the Patient's mother and other medical personnel were present during most of Patient A's visits and that one of the solicitations occurred during a phone call initiated by Patient A. More significantly, they note that there is no evidence in the record of any inappropriate physical or sexual contact during a medically justified pelvic exam or at any other meeting with Patient A. Therefore, a majority of the Hearing Committee does not sustain the Sixth Specification.

MORAL UNFITNESS

For the same reasons discussed in previous paragraph, a majority of the Hearing Committee does not find that Respondent's inappropriate solicitations and comments to Patient A rise to the level of moral unfitness. Therefore, the Seventh Specification is not sustained. It is further alleged that during his interview with OPMC, Respondent knowingly and intentionally falsely denied asking Patient A for a date. The Hearing Committee finds that Respondent lied to Dr. Shimm about asking the patient out. (T2. 14-19) They further find that he did not own up to this until he was confronted with the tape-recorded conversation. (Ex. 8, T1, p. 14)

It is further alleged that Respondent, with intent to deceive, knowingly and intentionally falsely altered his record regarding Patient A's March 8, 1996 visit with him by adding to the patient's complaints "4 Frequency of urination", and by adding to his impression "4 R/O UTI." After comparing Exhibits 3,4, and 5 , the Hearing Committee concurs with Dr. Lanyi (T 1. 145-148) and Dr. Shimm (T 2. 11-14) that the records are inconsistent for the same visits. The Hearing Committee further rejects as incredible Respondent's statement during the OPMC interview that he did not know who would have altered the records.

It is further alleged that Respondent knowingly and intentionally falsely created and/or submitted the aforesaid altered record to OPMC with the intention of deceiving OPMC when OPMC requested said records while Respondent was under investigation. Pursuant to the altered state of the records and Respondent's denials during his interview with Dr. Shimm, the Hearing Committee finds that the evidence supports this charge. Finally, it is further alleged that Respondent failed to maintain a record for Patient A that accurately reflects the care and treatment provided to Patient A. The Hearing Committee finds that an altered record jeopardizes the care of the patient by misrepresenting the true nature of her complaints and treatment.

The Hearing Committee is troubled by lengths Respondent went to in an attempt to conceal his inappropriate conduct towards Patient A. They conclude that altering the patient's record and lying to OPMC to cover-up the underlying misdeed rises to the level of moral unfitness. As a result,

the Hearing Committee sustains the Eighth through Eleventh Specifications.

FAILURE TO MAINTAIN RECORDS

The Hearing Committee has already found that altering a patient's records jeopardizes the care of the patient by misrepresenting the true nature of her complaints and treatment. Therefore, the Hearing Committee sustains the Twelfth Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a vote of 2 to1 that Respondent's license to practice medicine in New York State should be suspended for a period of three (3) years following the effective date of this Determination and Order. The suspension should be stayed in its entirety and Respondent shall be placed on probation. The Hearing Committee also assessed a civil penalty of Ten Thousand Dollars ($10,000). The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The majority of the Hearing Committee voted for a three year stayed suspension and civil penalty because they do not believe that revocation is commensurate with the level of professional misconduct in this instance. They found no evidence of explicit sexual overtones in his asking Patient A for a date. They further found no evidence that the pelvic examination was inappropriate or that Respondent had any inappropriate physical contact with Patient A. They note that most of her visits were out in the open with either her mother or someone else present. The Hearing Committee further found no evidence of a pattern of negligence by Respondent.

The majority of the Hearing Committee has found professional misconduct for fraud and moral unfitness solely for Respondent's attempt to cover-up his actions by lying to OPMC and

altering Patient A's records. They find that once confronted with Patient A's complaint, he lied and altered the records to protect himself from disciplinary action. The majority of the Hearing Committee believes that a civil penalty of $10,000 and a three (3) year stayed suspension with probation that includes record monitoring sends sufficient message to Respondent that cover-ups of this nature carry severe consequences. Under the totality of the circumstances, the majority of the Hearing Committee finds this penalty to be commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The Second, Third, Fourth and Eighth through Twelfth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The First, Fifth, Sixth and Seventh Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **THREE (3) YEARS,** said suspension to be **STAYED;** and

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. Respondent shall pay a civil penalty in the amount of **TEN THOUSAND DOLLARS ($10,000) within 30 days of the effective date of this Order;** and;

6. That any civil penalty not paid by the date prescribed herein shall be subject to all provisions of laws relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); State Finance Law, section 18; CPLR, section 5001; Executive Law, section 32)

7. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York
May 2, 2000

DANIEL W. MORRISSEY, O.P.
(Chairperson)

RUFUS NICHOLS, M.D.
ALVIN RUDORFER, M.D.

TO: Ann Gayle, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001

Barry M. Fallick, Esq.
Rochman, Platzer, Fallick & Sternheim, LLP
666 Third Avenue
New York, New York 10017

Swapnadip Lahiri, M.D.
52 Delford Avenue
Oradell, NJ 07649

APPENDIX I

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

IN THE MATTER

OF

SWAPNADIP LAHIRI, M.D.

AMENDED STATEMENT OF CHARGES

Swapnadip Lahiri, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20, 1993, by the issuance of license number 193715, by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a then 26 year old female, at Respondent's office which was located at North Bronx Medical, P.C., 799 Morris Park Avenue, Bronx, New York, from approximately March 8, 1996 to July 12, 1996.

1. Respondent failed to timely perform a necessary urine analysis upon Patient A.
2. On or about April 26, 1996 or May 24, 1996, in the course of a purported physical examination, but not for a proper medical purpose, Respondent touched Patient A inappropriately as follows:
   a. Respondent performed an unwarranted, unnecessary purported pelvic examination upon Patient A.
3. Respondent engaged in inappropriate conduct as follows:
   a. On or about May 28, 1996, Respondent asked Patient A for a date; when Patient A called Respondent back, Respondent again asked her for a

date.

b. On or about June 28, 1996, Respondent again asked Patient A for a date.

c. Throughout the course of treatment, Respondent made inappropriate verbal comments to Patient A.

B. On or about ~~July 1, 1998~~ June 5, 1991, Respondent, in an interview with the Office of Professional Medical Conduct, knowingly and intentionally falsely denied asking Patient A for a date.

C. Respondent, with intent to deceive, knowingly and intentionally falsely altered his record regarding Patient A's March 8, 1996 visit with him by adding to the patient's complaints "(4) Frequency of urination", and by adding to his impression "(4) R/O UTI".

D. Respondent knowingly and intentionally falsely created and/or submitted the aforesaid altered record to the Office of Professional Medical Conduct ("OPMC"), with the intention of deceiving OPMC when OPMC requested said records while Respondent was under investigation by OPMC.

E. Respondent failed to maintain a record for Patient A which accurately reflects the care and treatment provided to Patient A.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraphs A, A2 and A2a.
2. Paragraph B.

3. Paragraph C.

4. Paragraph D.

FIFTH 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. 1999) 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:

5. Paragraphs A and A1, A2 and A2a, C, and E.

SIXTH SPECIFICATION

WILLFULLY HARASSING, ABUSING AND INTIMIDATING A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31)(McKinney Supp. 1999) by willfully harassing, abusing and intimidating Patient A, as alleged in the facts of:

6. Paragraphs A, A2 and A2a, A3 and A3a, b, and/or c.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1999) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

7. Paragraphs A, A2, A2a, A3 and A3a, b, and/or c.

8. Paragraph B.

9. Paragraph C.

10. Paragraph D.

11. Paragraph E.

TWELFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) 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:

12. Paragraph E.

DATED: October 29, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board, addressed to the Director, Office of Professional Medical Conduct ("OPMC"), 433 River Street, Suite 303, Troy, New York 12180-2299 regarding any change in employment, practice, address, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of laws relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); State Finance Law, section 18; CPLR, section 5001; Executive Law, section 32)

7. Respondent shall maintain legible and complete hospital and office medical records which accurately reflect evaluation and treatment of patients. All hospital and office medical records shall contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record shall contain all information required by state rules and regulations regarding controlled substances.

8. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against the Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.