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

October 2, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Peter D. VanBuren, Esq.
NYS Department of Health
ESP -Corning Tower – Room 2509
Albany, New York 12237-0032

Edward H. Fox, Esq.
Harris, Beach & Wilcox, LLP
The Granite Building
130 East Main Street
Rochester, New York 14604

Hemant M. Pandhi, M.D.
8 Crabapple Lane
Cobleskill, New York 13036

RE: In the Matter of Hemant Pandhi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-270) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties other than suspension or revocation 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
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

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

COPY

IN THE MATTER OF HEMANT PANDHI, M.D.	DETERMINATION AND ORDER BPMC #00-270

A Notice of Hearing and Statement of Charges, dated March 9, 2000, were served upon the Respondent, **HEMANT PANDHI, M.D. KENDRICK SEARS, M.D.**, Chairperson, **JOHN H. MORTON, M.D.** and **SISTER MARY THERESA MURPHY**, 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 Sections 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.**, served as Administrative Law Judge for the Hearing Committee.

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

PROCEDURAL HISTORY

Department of Health Appeared by: **HENRY M. GREENBERG**, Esq.
General Counsel, NYS Dept. of Health

BY: **BRADLEY MOHR**, Esq.
Senior Attorney

Respondent appeared by: **EDWARD H. FOX**, Esq.
Harris, Beach & Wilcox, LLP
130 East Main Street
Rochester, New York 14604

Hearing Dates: April 27; May 23, 30;
June 2, 8, 9, 13, 2000

Witnesses for Department of Health:	Husband of Patient G; Patient G Wife of Patient I Sister of Patient F; Mother of Patient F Patient F Holly Lynn Frasier, R.N. Lynne Reale, R.N. Tracy Jo Sprague, R.N. Edith Freed, R.N. Daniel Padula, RPA Lisa McIntyre, R.N. Thomas C. Rosenthal, M.D. Mary Regina Johns, R.N.
Witnesses for Respondent:	Ingelore McLaughlin Carol Ferguson Patricia Chamberlain, R.N. Roy Parker, RPA William K. Marinis, RPA John Rusu, M.D. P.D., former member of the Moses-Ludington Hospital Board of Directors Hemant Pandhi, M.D. (Respondent)
Record closed:	July 19, 2000
Deliberations held:	July 24, 2000

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified. A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix I.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's Exhibits are designated by Letters.

T.= Transcript

GENERAL FINDINGS OF FACT

The Respondent was authorized to practice medicine in New York in 1990 by the issuance of license number 183095 by the New York State Education Department. (Ex. 3)

FINDINGS OF FACT RELATED TO PATIENT A

1. Patient A was a 64 year old male who presented to Respondent at the Emergency Room at Moses Ludington Hospital on October 18, 1997. (Ex. 5, p. 2; T. 558)

2. The patient presented with shortness of breath, likely due to exacerbation of chronic obstructive pulmonary disease. He was afebrile with an initial oxygen saturation of 69% and arterial blood gas with a ph of 7.289. (Ex. 5, p. 3; T. 558)

3. The organ systems that are relevant to the chief complaint are generally charted by physicians as a way of giving a picture of the patient on paper. If something is not charted, the assumption is that it has not been performed. Acceptable medical standards require that both the pertinent positives and negatives be included in the chart of a patient with acute complaints to establish that the physician is aware of the full picture of the patient. (T. 560-1, 587-8, 595)

4. Respondent's chart did not contain sufficient information about the patient's chronic lung disease, such as whether or not the patient had been previously admitted and if he had been intubated in the past. The initial physical examination performed and documented by Respondent for Patient A should have included an examination of the cardiovascular system, specifically the heart, and an examination of the lower extremities to check for edema and signs of fluid accumulation. He did not percuss or otherwise examine the patient's chest and lungs. (T. 169, 227, 561-562, 988)

5. The patient had an arterial blood gas ph on admission of 7.289, below the lower range of normal of 7.35-7.45. This ph level indicated that Patient A had some degree of respiratory decompensation (acidosis) related to his respiratory complaints and was evidence of a patient with significant chronic lung disease (Ex. 5, p. 4; T. 565-68)

6. Cyanotic nail-beds and sitting forward to breathe were additional indications of significant distress on the part of the patient as was the arterial blood gas bicarbonate level of 38.5 MEQ/L, as documented in the medical record. Respondent erroneously recorded this value as 28.5 (Ex. 5, pp. 2-3, 6; Ex.5A, p. 1; T. 596-597, 992-4)

7. Respondent treated the patient with a cortisone, Solu-Medrol, and an antibiotic, Zinacef, which would not have provided immediate relief and failed to provide the patient an inhaler or some other form of therapy which would have afforded more immediate relief. Respondent also failed to have Patient A's ph level checked before discharge to ensure that he was improving. (Ex. 5, p. 2, Ex. 5A, p. 1; T. 566-567)

FINDINGS OF FACT RELATED TO PATIENT B

8. Patient B, a 46 year old male, had a four day history of exacerbation of back pain that radiated down his left leg and presented to Respondent at the Emergency Room at Moses Ludington Hospital on March 5, 1998. (Ex. 1, pp. 2, 6; T. 604)

9. Patient B had a history of severe low back pain. His blood pressure reading of 201/119 on admission was indicative of severe hypertension. He had taken 30 Percocet tablets over the prior three days for pain and ambulated into the Emergency Room using crutches. (Ex. 6, p. 4; T. 604, 611-612)

10. Respondent performed no neurological examination of the patient's lower extremities and no examination of his cardiovascular system and failed to determine whether the patient was in a sinus or normal heart rhythm or that he did not have other evidence of cardiovascular disease or decompensation. (T. 605, 616-619, 1030-1)

11. Failure to do a proper cardiovascular examination could have caused overcompensation in treating the patient's blood pressure with the result that he may have become hypotensive. This could have led to serious risk to the patient including the possibility of stroke or heart attack. Failure to perform a proper neurologic examination could have caused the inability to recognize a cauda equina syndrome or other major effect of a herniated disk with resultant paralysis. (T. 606, 615-617, 618)

12. The medical record maintained for Patient B was below acceptable standards because it did not document a proper examination or contain an adequate medical history. (Ex. 6, pp. 6-7; T. 607, 615-9)

FINDINGS OF FACT RELATED TO PATIENT C

13. Patient C was a 37 year old female who presented to Respondent at the Emergency Room at Moses Ludington Hospital on March 26, 1998 with a history of headache accompanied by photo phobia and vomiting. (Ex. 7; T. 622)

14. Although Respondent documented the results of a physical examination of Patient C, he never actually conducted such an examination of the patient on March 26, 1998. (Ex. 7, pp. 6-7; T. 235-239)

15. Patient C was treated with an injectable narcotic medication, Demerol 75 mg. and Vistaril 50 mg. Patient C was given Demerol at 1:00 PM and was discharged at 1:10 PM, only 10 minutes later. Injectable Demerol takes 10 to 15 minutes to be absorbed. The standard of care requires that the patient be observed for at least the length of time it takes for an injectable drug to take effect. The patient had not yet shown an improvement when discharged as indicated by the fact that the Discharge Acuity Level was "unchanged." (Ex. 7, p. 4; T. 623-627)

FINDINGS OF FACT RELATED TO PATIENT D

16. Patient D was a 57 year old female who presented to Respondent at the Emergency Room at Moses Ludington Hospital on January 11, 1998 with a complaint of severe shortness of breath (acute respiratory distress) and an initial oxygen saturation of 66 percent. (Ex. 8, pp. 6, 7-8, 12-14; T. 636, 650)

17. The patient was given Ativan, a benzodiazepam class of sedative hypnotic medication. Administering Ativan to a patient struggling to maintain their oxygen level can suppress their ability to maintain their respiratory effort. (Ex. 8, pp. 6, 7, 11, 14; T. 636-367)

18. Aminophylline, a medication with a very narrow therapeutic range, was also given to the patient. Ativan could counteract the signs used to monitor the patient's reactions to Aminophylline and could result in Aminophylline toxicity; headache, tremor, nausea and seizures. (Ex. 8, pp. 6-8, 14; T. 639-640)

19. Respondent issued a verbal order to administer Aminophylline to Patient D without specifying a dosage and instructed an assisting nurse that it be turned "wide open" as an IV bolus. The written order for this patient as found in the medical record was for a 400 milligram bolus at 40 milligrams per hour. (Ex. 8, p. 6; T. 277, 302, 315, 642, 740, 769, 771, 774)

20. Assisting nurses consulted the Nursing Drug Book for an appropriate dose for Aminophylline and then started a drip. Respondent, after consulting with the nurses, agreed with the dosage, wrote the order which was subsequently administered. (T. 280, 283, 740-741, 769)

FINDINGS OF FACT RELATED TO PATIENT E

21. Patient E was a 91 year old female who presented to Respondent at the Emergency Room at Moses Ludington Hospital on March 12, 1998 after having been found on the floor of her home. She was alert but shaking and exhibited weakness, garbled speech, an increased facial droop on the left side, nausea and incontinence of bowel and urine. Patient E was admitted with a diagnosis of syncope, ruling out myocardial infarction, seizures and hypertension. (Ex. 9, pp. 6, 10-12; T. 653-654, 658-659)

22. The patient's symptoms were consistent with a stroke or a seizure or both. Minimally acceptable medical standards for a patient with these symptoms, given the admitting differential diagnosis, would require an examination for proper diagnosis of a syncopal episode, a neurological impact examination for stroke or seizure, and an examination for lateralizing signs. (T. 656, 659)

23. Respondent ordered that a Foley catheter be placed, an IV with Ringer lactate, an EKG and some lab tests for the patient. (Ex. 9; T. 336, 339-40)

24. Although Respondent documented an initial physical examination in the patient's medical chart, he never actually performed a physical or neurological examination of Patient E. (Ex. 9, pp. 10-12; T. 323-327, 363-368)

FINDINGS OF FACT RELATED TO PATIENT F

25. Patient F was a 39 year old female who presented with vaginal hemorrhaging to Respondent at the Emergency Room at Chenango Memorial Hospital on June 14, 1999. (Ex. 10, pp. 2, 3, 11-15; T. 137, 662)

26. Patient F was 5 weeks postpartum with a history of an emergency C-section, insulin dependent diabetes mellitus, pulmonary embolism, depression, venous varicosities with deep venous thrombosis, and was taking Heparin and Coumadin. (Ex. 10, pp. 2, 3, 11-15; T. 137, 662)

27. Based on the complaints and history of Patient F, an adequate examination should have included a pelvic or vaginal examination, bi-manual or gloved; observation of her C-section scar and her vaginal area to observe her bleeding; examination of her pad or "chux" and a quantification of her rate of bleeding, such as number of pads that had been used and soaked through. (T. 663, 666, 674)

28. Although Respondent charted a physical examination that indicated an examination of the patient's head, eyes, nose, throat, neck, chest and respiration, the cardiovascular, abdominal, musculoskeletal systems and the skin, he did not actually conduct or attempt to conduct such an examination. (T. 107-110, 120, 125-128, 139-144)

29. The patient did not refuse or resist any portion of the examination and there is no indication in her record of any such refusal. If the pelvic examination had been refused by Patient F, that fact should have been recorded in her record, with a recommendation that she have a pelvic examination performed elsewhere. (T. 109-110, 128, 142, 677-679)

FINDINGS OF FACT RELATED TO PATIENT G

30. Patient G was a 60 year old woman who presented to Respondent at the Emergency Room at Chenango Memorial Hospital on June 14, 1999 with a chief complaint of chills, swelling in her right leg and a history of chronic lymph edema of the legs, hypertension, diabetes, hyper-lipemia, obesity, diabetes and glaucoma. She had a temperature of 99.3, and a white cell count of 17,900 with a left shift. (Ex. 11, pp. 86-100; T. 23, 47, 686-688)

31. An appropriate examination of the patient, based on her complaints and history, would have required Respondent to uncover and lift her legs and to examine them front and back. Respondent should have pushed on the leg with a thumb or finger to quantify the amount of edema present. The pulses should have been checked to ensure that blood flow to the legs was sufficient, thereby ruling out abnormal or decreased blood flow to the leg as a contributing or aggravating factor. (T. 693)

32. Although Respondent recorded a physical examination that indicated an examination of the head, eyes, nose, throat, neck, chest and respiration, the cardiovascular, abdominal, musculoskeletal systems and the skin, he did not actually perform such an examination. (Ex. 11, p. 87; T. 24-26, 48-50)

FINDINGS OF FACT RELATED TO PATIENT H

33. Patient H was a 26 year old male, from Camp Georgetown (a correctional facility) who presented to Respondent at the Emergency Room at Chenango Memorial Hospital on June 5, 1999 with a complaint of epigastric pain with vomiting. (Ex. 12, pp. 59-68; T. 444, 701)

34. Respondent documented a complete physical examination and noted an elevated white blood cell count at 13,100. He placed the patient on antibiotics and Reglan and discharged the patient to follow-up with a surgeon. (Ex. 12, p. 60; T. 701, 704)

35. The patient's condition was stable and he was not a candidate for immediate surgery. An elective cholecystectomy was performed on July 9, 1999. (Ex. 12, p. 5; T. 1221-1226)

FINDINGS OF FACT RELATED TO PATIENT I

36. Patient I was an 83 year old male, who presented to Respondent at the Emergency Room at Chenango Memorial Hospital on May 18, 1999 following a head injury suffered from a fall at home. (Ex. 13, pp. 108-112; T. 78, 718)

37. The patient had a history of recurrent deep venous thrombosis, a previous subdural hematoma with a ventricular peritoneal shunt and some brain damage. (Ex. 13 pp. 108-112; T. 80, 718-719)

38. Based upon the patient's admitting complaint of head injury and his medical history, an extensive examination including an examination of the neurologic system to determine if there was any localizing signs of suggestion of stroke, an examination of the head and skull or scalp to check for injury from the fall and an examination of the extremities to check for other possible unreported injuries would have been appropriate. (T. 719-720)

39. Although Respondent charted an extensive physical examination that indicated an examination of the patient's vital signs, his head, eyes, nose, throat, neck, chest and respiration; the cardiovascular, abdominal and musculoskeletal systems and the skin, he did not actually perform such an examination. He ordered x-rays and blood tests for the patient. (Ex. 13, p. 109-112; T. 81-4, 514)

CONCLUSIONS OF LAW

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

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED** based on the above Findings of Fact:

Paragraphs A., A. 1., A. 2., A. 3. and A. 4.;

Paragraphs B., B. 1. and B. 2.;

Paragraphs C., C. 1., C. 2., C. 3. and C. 4.;

Paragraphs D. and D. 1.;

Paragraphs E., E. 1. and E. 2.;

Paragraphs F., F. 1. and F. 2.;

Paragraphs G., G. 1. and G. 2.;

Paragraphs I., I. 1., and I. 2.;

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that the following Specifications of Professional Misconduct should be **SUSTAINED** based on the Factual Allegations which were sustained as set out above:

Third, Fifth, Sixth, Seventh and Ninth Specifications;

Nineteenth Specification;

Twentieth Specification;

Twenty-first through Twenty-sixth and Twenty-eighth Specifications;

Twenty-ninth through Thirty-second and Thirty-fourth Specifications;

Thirty-fifth through Thirty-eighth and Fortieth Specifications.

The Hearing Committee determined that all other Specifications of Professional Misconduct should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories 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 certain types of professional misconduct.

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

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraudulent practice of medicine is the intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

The Committee recognized that it was essential to evaluate the testimony of each witness to determine his or her credibility and the appropriate weight to be assigned to each witness' testimony. Dr. Rosenthal was considered by the Committee to be very familiar with, and experienced in the practice of medicine in a small rural hospital. The acceptable standards of care in a smaller rural hospital were

viewed as similar to those in larger facililities. His testimony was considered to be objective and his opinions were based on open-minded thinking and were not seen as dogmatic. In fact, some opinions were considered to be very favorable to the Respondent. Dr. Rosenthal was not always in full agreement with the Department's positions and was seen as honest and persuasive. The Committee found his testimony to be most credible and relied heavily on his expert opinions. In certain cases he found the medical records to be acceptable based on assumptions that Respondent had actually performed the examinations as charted. In those cases in which the Committee concluded that such examinations had not been performed, it was determined that those records were fraudulent and did not meet acceptable standards of record keeping.

The Committee believed Respondent's testimony to be evasive and self-serving. He too frequently placed responsibilities that were his own on nursing staff. Several explanations of his examinations of patients were simply not worthy of belief. For example, Respondent testified that Patient B was in so much pain that he refused to move or allow an examination of his leg; however Respondent recorded back tenderness. He testified that he performed a neurological examination of Paient B's legs and found normal sensation. However, such a finding that clearly related to the complaint of back pain was not recorded. The Committee felt Respondent had an obvious motive to cloud the truth and inconsistencies between his testimony and the medical records resulted in a conclusion that he was not a credible witness.

Respondent alleged that the hospital staff who testified against him were biased and motivated by a dislike of a foreign-born physician or an "outsider". The contention that Respondent was the only foreign physician in the Ticonderoga area was contradicted by the testimony, on Respondent's behalf, of Dr. Rusu, a Rumanian radiologist with attending privileges at Moses Ludington Hospital. The Committee felt the allegation of prejudice by the nursing staff was further discredited by the fact that staff of two separate facilities hundreds of miles apart testified similarly as to Respondent's failure to perform physical examinations. In addition, the patients themselves, as well as family members present at the time, likewise offered similar testimony. The Committee members felt that these witnesses would have no motive to distort the truth and found them to be very credible. The numbers of credible witnesses who verified Respondent's actions and failures to act established a pattern of unacceptable behavior and professional misconduct.

CONCLUSIONS RELATED TO PATIENTS TREATED AT MOSES-LUDINGTON HOSPITAL

Patient A's medical history was inadequately documented because his chronic lung disease was not fully addressed. The medical record did not indicate an examination of the cardiovascular system or lower extremities, each of which was relevant based on the complaint of shortness of breath. Respondent testified that he did not percuss Patient A's chest or lungs. The Committee considered both the examination of the patient and the charting of such exam to be below acceptable standards of practice. Respondent also failed to treat the patient in a manner to provide more immediate relief and discharged the patient without monitoring the ph level. The Committee felt that it was unacceptable for Respondent to place the responsibility for discharging the patient on nursing staff when it was ultimately his obligation to ensure that it was safe to do so. All Factual Allegations related to Respondent's treatment of Patient A wetre sustained.

The Respondent alleged that he could not examine Patient B's leg in response to his complaint of back pain radiating down his leg because the patient was in too much pain. Any alleged refusal of treatment was not documented and the Committee felt Respondent's testimony was not credible. As a result of the patient's alleged refusal to be examined, no neurological examination was performed by the Respondent. He also failed to document the results of any cardiovascular exam or detail Patient B's history of severe low back pain. The Committee determined that the examination and documentation of findings from such examination did not meet acceptable medical standards and sustained Factual Allegations B.1. and B.2.

The Committee considered the testimony of the hospital's Director of Nursing credible and, relied on that testimony to conclude that Respondent conducted no physical exam of Patient C on March 26, 1998. Accordingly, the results of the alleged exam charted in the patient's record was determined to be fraudulent. Falsifying medical records was viewed as an egregious deviation from accepted standards of practice constituting practice of the profession with gross negligence, as well as evidence of moral unfitness and the failure to maintain a medical record accurately reflecting the evaluation and treatment of the patient. The discharge of the patient only 10 minutes after injections of Demerol and Vistaril was the ultimate responsibility of the Respondent as the nursing staff was under his supervision. The Committee considered

the premature discharge to be a deviation from accepted standards of practice and sustained Factual Allegation C.3. In evaluating Respondent's overall competence, the Committee members noted his testimony in regard to the alleged exam of the patient in which Respondent stated that he performed breast examinations on patients by simply palpating the breast through clothing. The Committee believed such a practice to be clear evidence of a lack of skill and knowledge in the practice of medicine.

Treating Patient D, who complained of respiratory distress, with Ativan was determined to be an indication of Respondent's absence of medical skill and knowledge. Such medication was contraindicated and could have reduced the patient's awareness of the need for oxygen. Allegation D.1. was sustained. The Committee believed that Respondent ordered an Aminophylline drip for Patient D to be administered wide open. However, the members did not conclude that the act constituted professional misconduct because the nursing staff ultimately administered the medication in the proper dosage. Therefore, Allegation D.2. was not sustained.

The Committee found the Emergency Room nurse who was present when Respondent saw Patient E to be a credible witness. Her testimony that Respondent performed no physical examination of the patient was believable and was supported by testimony from a Physician's Assistant who was also present. The Respondent, at a minimum, should have performed a neurological exam based on Patient E's presenting condition. Factual Allegations E. 1. and E. 2. were sustained. The Committee decided that Respondent's failure to perform an appropriate exam was not an egregious deviation from accepted standards only because he had previously treated the patient and was somewhat familiar with her. Therefore, the Specification of practicing with gross negligence was not sustained in this case. The fact that Respondent documented an examination that the Committee determined did not take place resulted in a conclusion that Respondent practiced in a fraudulent and morally unfit manner.

CONCLUSIONS RELATED TO THE TREATMENT OF PATIENTS AT CHENANGO MEMORIAL HOSPITAL

Patient F, her sister and her mother each testified that Respondent performed no physical exam in response to the patient's complaint of vaginal bleeding. Patient F, a nurse, stated that she had once falsified

a patient's medical record. The Committee considered this history, but believed her testimony to be forthright and direct and that she would understand the implications of creating a false record. The allegation by the Respondent that the patient refused to consent to a vaginal exam was not documented in the chart and was not credible as it would not have been logical for her to refuse an exam directly related to the complaint. The three witnesses were seen as credible and objective and all Allegations were sustained. The Committee did not consider Respondent's deviation from accepted standards of practice in failing to adequately evaluate, monitor and treat the bleeding to be so great as to constitute gross negligence only because he discontinued the patient's treatment with Coumadin.

The Committee considered the testimony of Patient G and her husband to be consistent and felt that the husband was clear in his recollection that he was present throughout her stay in the Emergency Room on June 14, 1999 and that Respondent did not conduct a physical of the patient. Factual Allegations G.1. and G.2. were sustained as were Specifications of gross negligence, fraud and moral unfitness. Allegation G. 3. was not sustained because there was no evidence presented to demonstrate that the patient actually had septicemia.

Unlike the cases involving other patients, only one nurse testified that Respondent did not perform a physical examination on Patient H. The patient was an inmate at the time he was treated and did not testify. The Committee felt that without some corroboration , the preponderance of evidence in the record, did not establish that Respondent did not perform an exam. Allegations H. 1. and H. 2. were not sustained. It was also determined that whether the patient was a candidate for immediate surgery was a judgement call and that Respondent appropriately ordered antibiotics for the patient with directions to follow-up with a surgeon. It was noted that the patient's abdominal pain had been an on-going condition and that elective surgery was performed one month later. Allegation H. 3. was not sustained.

The Committee considered Patient I's wife to be very credible in testifying that Respondent did not examine her husband after he sustained a head injury following a fall. She testified that she arrived at the Emergency Room before Respondent and this was confirmed by both the nurse that was present and the patient's medical record. Patient I's wife further stated that she remained with the patient the entire time he was in the Emergency Room. The Committee believed that she had a clear and consistent recollection of the events surrounding the visit to the Emergency Room and determined that no physical exam was

performed. Factual Allegations I. 1 and I. 2. were sustained. Based on the patient's history of a previous head injury, the failure to perform a physical exam was considered to be gross negligence. Documenting an examination that did not occur was determined to be the fraudulent practice of medicine, evidence of moral unfitness and the failure to maintain accurate records.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. 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 Committee sustained multiple Specifications of Respondent's having practiced with gross negligence, gross incompetence, negligence and incompetence on more than one occasion, in a fraudulent manner, in a manner evidencing moral unfitness and having failed to maintain accurate medical records. Certain actions of the Respondent raised questions in the minds of the Committee members as to his level of skill and knowledge, such as ordering that an Aminophylline drip be administered wide open to Patient D. The statement that Respondent performed breast exams on female patients without having them undress was considered to be improper. He often provided contradictory answers to questions about his treatments, which cast doubt on his level of medical skill. The fact that numerous witnesses, including patients and their family members as well as nursing staff, each confirmed that physical examinations that were charted were not actually performed revealed an unacceptable pattern of practice that put patients at risk. Respondent's fundamentally dishonest methods made any penalty less severe than license revocation inappropriate.

ORDER

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

1. The following Specifications of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

   a Third, Fifth, Sixth, Seventh and Ninth Specifications;

   b. Nineteenth Specification;

   c. Twentieth Specification;

   d. Twenty-first through Twenty-sixth and Twenty-eighth Specifications;

   e. Twenty-ninth through Thirty-second and Thirty-fourth Specifications;

   f. Thirty-fifth through Thirty-eighth and Fortieth Specifications.

2. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

3. 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: Troy, New York

September 22, **2000**

KENDRICK A. SEARS, M.D. CHAIRPERSON

JOHN H. MORTON, M.D.
SISTER MARY THERESA MURPHY

TO:

Peter D. Van Buren, Esq.
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Cobleskill, New York 13036

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
HEMANT PANDHI, M.D.	:	CHARGES

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Hemant Pandhi, M.D., Respondent, was authorized to practice medicine in New York State in 1990 by the issuance of license number 183095 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period March 1, 2000 through February 28, 2002, with an address of 8 Crabapple Lane, Cobleskill, New York 12043.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, (patients are identified in the attached appendix) a 64 year old male presenting with shortness of breath in the Emergency Room of Moses-Ludington Hospital in Ticonderoga, New York on or about October 18, 1997. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.
2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately respond to patient's abnormal blood Ph levels.

B. Respondent treated Patient B, a 46 year old male, who presented with acute back pain in the Emergency Room of Moses-Ludington Hospital in Ticonderoga, New York on or about March 5, 1998. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform and/or document an adequate initial physical examination.

2. Respondent failed to maintain a complete and/or accurate medical record.

C. Respondent treated Patient C, a 37 year old female, who presented with a headache, photo phobia and vomiting in the Emergency Room of Moses-Ludington Hospital in Ticonderoga, New York on or about March 26, 1998. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.

2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.

3. Respondent failed to adequately evaluate, monitor and/or treat the patient's headache, photo phobia and vomiting, in that he administered IM Demerol (meperidine) and Vistaril (hydroxyzine) and failed to observe the patient for an adequate period of time before discharging her.

4. Respondent failed to maintain a complete and/or accurate medical record.

D. Respondent treated Patient D, a 57 year old female, who presented with shortness of breath in the Emergency Room of Moses-Ludington Hospital in Ticonderoga, New York on or about January 11, 1998. Respondent's care and treatment did not meet acceptable standards, in that:

1. Respondent failed to adequately evaluate, monitor and/or treat the patient's dyspnea in that Respondent ordered the administration of Ativan (lorazepam).

2. Respondent failed to adequately evaluate, monitor and/or treat the patient's dyspnea in that Respondent ordered an Aminophylline (theophylline)drip for the patient to be turned wide open.

E. Respondent treated Patient E, a 91 year old female, who presented with shaking, weakness and a history of a recent seizure in the Emergency Room of Moses-Ludington Hospital in Ticonderoga, New York on or about March 12, 1998. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.

2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.

F. Respondent treated Patient F, a 39 year old female, who presented with post-partum vaginal hemorrhaging of four hours duration occurring five weeks after a C-section delivery and with a history of diabetes in the Emergency Room of

Chenango Memorial Hospital in Norwich, New York on or about June 14, 1999. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.
2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.
3. Respondent failed to adequately evaluate, monitor and/or treat the patient's vaginal bleeding.

G. Respondent treated Patient G, a 60 year old female, who presented with chills, fever and swelling in her leg and a history of lymph edema of the legs and hypertension in the Emergency Room of Chenango Memorial Hospital in Norwich, New York on or about June 14, 1999. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.
2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.
3. Respondent failed to adequately evaluate, monitor and/or treat the patient's septicemia from cellulitis.

H. Respondent treated Patient H, a 28 year old male inmate from Camp Georgetown Correctional Facility, who presented with pain in the epigastric area radiating to the back and vomiting and a history of gallbladder problems in the

Emergency Room of Chenango Memorial Hospital in Norwich, New York on or about June 5, 1999. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.
2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.
3. Respondent failed to adequately evaluate, monitor and/or treat the patient's abdominal pain.

I. Respondent treated Patient I, an 83 year old male, who presented with a head injury resulting from a fall and a history of recurrent deep venous thrombosis and a previous subdural hematoma with a ventricular-peritoneal shunt, in the Emergency Room of Chenango Memorial Hospital in Norwich, New York on or about May 18, 1999. Respondent's care and treatment did not meet acceptable standards of care, in that:

1. Respondent failed to perform an adequate initial physical examination.
2. Respondent fraudulently documented in the record that he performed an examination that he did not in fact perform.

SPECIFICATIONS

FIRST THROUGH NINTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4), in that Petitioner charges the following:

1. The facts in paragraphs A and A.1, A and A.2, A and A.3 and/or A and A.4;
2. The facts in paragraphs B and B.1 and/or B and B.2.
3. The facts in paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.
4. The facts in paragraphs D and D.1 and/or D and D.2.
5. The facts in paragraphs E and E.1, and/or E and E.2.
6. The facts in paragraphs F and F.1, F and F.2 and/or F and F.3.
7. The facts in paragraphs G and G.1, G and G.2 and/or G and G.3.
8. The facts in paragraphs H and H.1, H and H.2 and/or H and H.3.
9. The facts in paragraphs I and I.1 and/or I and I.2.

TENTH THROUGH EIGHTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges the following:

10. The facts in paragraphs A and A.1, A and A.2, A and A.3 and/or A and A.4.
11. The facts in paragraphs B and B.1 and/or B and B.2.
12. The facts in paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.
13. The facts in paragraphs D and D.1 and/or D and D.2.
14. The facts in paragraphs E and E.1 and/or E and E.2.
15. The facts in paragraphs F and F.1, F and F.2 and/or F and F.3.
16. The facts in paragraphs G and G.1, G and G.2 and/or G and G.3.
17. The facts in paragraphs H and H.1, H and H.2 and/or H and H.3.
18. The facts in paragraphs I and I.1 and/or I and I.2.

NINETEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges two or more of the following:

19. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4; B and B.1, B and B.2; C and C.1, C and C.2, C and C.3, C and C.4; D and D.1, D and D.2; E and E.1, E and E and E.2; F and F.1, F and F.2, F and F.3; G and G.1, G and G.2, G and G.3; H and H.1, H and H.2 and/or H and H.3.

TWENTIETH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more that one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

20. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4; B and B.1, B and B.2; C and C.1, C and C.2, C and C.3, C and C.4; D and D.1, D and D.2; E and E.1, E and E.2; F and F.1; F and F.2; F and F.3; G and G.1, G and G.2, G and G.3; H and H.1, H and H.2 and/or H and H.3; I and I.1, I and I.2.

TWENTY-FIRST THROUGH TWENTY-EIGHTH SPECIFICATIONS

FAILING TO MAINTAIN MEDICAL RECORDS

Respondent is charged with having failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient in violation of New

York Education Law §6530(32), in that Petitioner charges:

21. The facts in paragraphs A and A.1, A and A.2 and/or A and A.3.
22. The facts in paragraphs B and B.1 and/or B and B.2.
23. The facts in paragraphs C and C.1, C and C.2 and/or C and C.4.
24. The facts in paragraphs E and E.1 and/or E and E.2.
25. The facts in paragraphs F and F.1, F and F.2 and/or F and F.3.
26. The facts in paragraphs G and G.1 and/or G and G.2.
27. The facts in paragraphs H and H.1, H and H.2.
28. The facts in paragraphs I and I.1, and/or I and I.2.

TWENTY-NINTH THROUGH THIRTY-FOURTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530(2), in that Petitioner charges:

29. The facts in paragraph C.2.
30. The facts in paragraph E.2.
31. The facts in paragraph F.2.
32. The facts in paragraph G.2.
33. The facts in paragraph H.2.
34. The facts in paragraph I.2.

THIRTY-FIFTH THROUGH FORTIETH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

35. The facts in paragraph C.2.
36. The facts in paragraph E.2.
37. The facts in paragraph F.2.
38. The facts in paragraph G.2.
39. The facts in paragraph H.2.
40. The facts in paragraph I.2.

DATED: March 9, 2000
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct