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., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 22, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Padmanabha Pulakhandam, M.D.
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Elmhurst, New York 11373

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420 Lakeville Road
Lake Success, New York 11042

RE: In the Matter of Padmanabha Pulakhandam, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-61) 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.

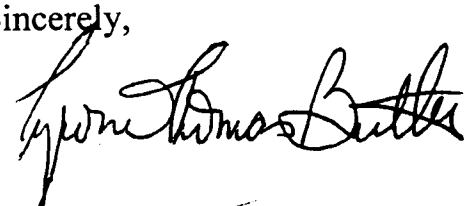
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

COPY

IN THE MATTER

OF

PADMANABHA PULAKHANDAM, M.D.

DETERMINATION
AND
ORDER
BPMC 02 - 61

JERRY WAISMAN, M.D., (Chairperson), **PRAKASH C. SAHARIA, M.D.**, and **REVEREND EDWARD J. HAYES** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, ("**ALJ**") served as the Administrative Officer.

The Department of Health appeared by **NANCY STROHMEYER, ESQ.**, Assistant Counsel.

Respondent, **PADMANABHA PULAKHANDAM, M.D.**, appeared personally and was represented by **KERN AUGUSTINE CONROY & SCHOPPMANN, P.C.** by **T. LAWRENCE TABAK, ESQ.**, and **WENDY A. STIMPFL, ESQ.** , of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	November 9, 2001
Date of Statement of Charges:	November 9, 2001
Date of Service of Notice of Hearing and Statement of Charges:	November 9, 2001
Date of Answer to Charges:	November 20, 2001
Pre-Hearing Conference Held:	November 29, 2001
Hearings Held: - (First Hearing day):	December 12, 2001 December 17, 2001
Post-Hearing Conference Held:	December 17, 2001
Department's Proposed Findings of Fact, Conclusions of Law and Sanction:	Received January 18, 2001
Respondent's Summation Findings of Fact and Conclusions of Law:	Received January 22, 2001
Witness called by the Petitioner, Department of Health:	Howard Goldstein, M.D.
Witnesses called by the Respondent, Padmanabha Pulakhandam, M.D.	Padmanabha Pulakhandam, M.D.
Deliberations Held: (last day of Hearing)	January 25, 2002

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the Public Health Law of the State of New York ["**P.H.L.**"]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Department**") pursuant to §230 of the P.H.L.

Padmanabha Pulakhandam, M.D., ("**Respondent**") is charged with two specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: (1) practicing the profession with negligence on more than one occasion[1]; and (2) practicing the profession with incompetence on more than one occasion[2].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct and diagnoses of six patients [3]

Respondent admits to being licensed and registered to practice medicine in New York. Respondent denies all specifications of misconduct.

A copy of the Statement of Charges and the Answer is attached to this Determination and Order as Appendix I and II respectively.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable

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[1] Education Law §6530(3) and First Specification of the Statement of Charges (Department's Exhibit #1).

[2] Education Law §6530(5) and Second Specification of the Statement of Charges (Department's Exhibit #1).

[3] Patients A through F are identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1). The Factual Allegation and Specification of misconduct as to Patient B was withdrawn by the Department on the first day of the Hearing.

or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on March 22, 1990 by the issuance of license number 181746 by the New York State Education Department (Department's Exhibits # 1 and # 3); (Respondent's Exhibit # A)[4]; [T-222-223][5].

2. Respondent received his medical degree in India in 1966, joined the Indian Air Force and after finishing military service taught medical physiology at an Indian medical school for 13 years [T-223-224]. In 1984 he immigrated to the United States. His first American employment was at Downstate Medical Center in Brooklyn, New York where Respondent worked as a researcher and professor of physiology. Respondent completed a five year residency program in pathology at Kings County Downstate Medical Center. In his final year of residency he was the chief resident in pathology [T-225]. Subsequently, Respondent received fellowship training in transfusion medicine and blood banking at the New York Blood Center. On completion of his fellowship, Respondent served as assistant director of the New York Blood Services until June of 1994 (Respondent's Exhibit # B); [T-225]. Due to personal responsibilities Respondent was away from medicine for sometime [T-225-226].

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[4] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Padmanabha Pulakhandam (Respondent's Exhibit #).

[5] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing transcript.

3. In May 1995, Respondent obtained board certification in clinical and anatomic pathology [T-228]. From July, 1995 through December, 1995, Respondent served as a visiting fellow and instructor in anatomic pathology at Kings County Hospital Center (Respondent's Exhibit # B); [T-226-227].

4. From January, 1996 through July, 1996, Respondent was the associate director of Enzo Clinical Laboratories ("**Enzo**") in Farmingdale, New York (Respondent's Exhibit # B); [T-228-230] and was directly responsible for the administrations of this out patient facility [T-284-285].

5. At Enzo, Respondent viewed between 50 and 70 surgical biopsies per day in addition to reviewing non-surgical pathology slides and to his administrative duties [T-289].

6. In December, 1996 Respondent obtained a position as an attending pathologist at Nassau University Medical Center in Long Island, New York and continues to work in that setting and position. Respondent is presently a full-time surgical pathologist who performs surgical and cytopathology work. He is also assistant director of the blood bank at Nassau University (Respondent's Exhibit # B); [T-232-233].

7. All of the allegations of misconduct involved work done by Respondent while employed at Enzo. There have been no allegations of misconduct with regard to Dr. Pulakhandam's medical practice since April 1996 (Department's Exhibit # 1); [T-221-382].

8. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); [P.H.T-18].

PATIENT A

Factual Allegation A.1. is sustained.

9. On March 13, 1996, Respondent reviewed and reported on a cervical tissue specimen obtained from Patient A by means of an endocervical curettage ("**ECC**") (Department's Exhibits # 4 and # 9A, slide no. 96S1502A; and # 21a, 21c, 21d, 21f); [T-31].

10. Respondent diagnosed squamous metaplasia and chronic cervicitis in his March 13, 1996 report (Department's Exhibit # 4); [T-32, 241].

11. Squamous metaplasia is a transformation of one type of epithelium into another type of epithelium. Squamous metaplasia was present in the March, 1996 specimen [T-78, 241]. Chronic cervicitis is the presence of inflammatory cells in the interstitial area in the specimen [T-242]. Chronic cervicitis was present in the March, 1996 specimen [T-62, 79, 242].

12. A diagnosis of chronic cervicitis is not a normal diagnosis and alerts the treating physician of additional problems with the patient [T-81].

13. The March, 1996 specimen from Patient A contained a small fraction of cells identified as adenocarcinoma in situ, as evidenced by the existence of mitotic figures, which are seen in rapidly growing cells, and other atypical cellular structures with disorganization of the tissue [T-41-44]. Adenocarcinoma is an infrequent diagnosis (infrequent cancer occurrence) in the cervix [T-50, 265].

14. Although squamous metaplasia was present in the sample, it was less clinically significant than the presence of the malignant cells. Pathologists must report the most clinically significant information to the clinician [T-43-45, 65, 110].

15. The adenocarcinoma in situ found in the March, 1996 sample is a malignancy, which exists in the surface (lining) of the epithelial tissues. It is developing within its place of origin and has not invaded underlying tissue [T-59].

16. Adenocarcinoma of the cervix is an infrequent diagnosis, but a reasonably prudent pathologist is expected to recognize and appropriately diagnose the condition. Failure to diagnose

an adenocarcinoma of the cervix in situ is a deviation from minimally acceptable standards of medical care [T-50-51, 63, 109].

17. Respondent admitted that he misdiagnosed the March, 1996 specimen. Respondent conceded that he failed to discern the adenocarcinoma in situ and that the cancer was the most clinically significant diagnosis of the March, 1996 sample [T-249-250, 273].

18. Respondent misdiagnosed the March 13, 1996 specimen of Patient A (Department's Exhibit # 4); [T-41-45, 50-51, 63-65, 109-110, 249-250].

19. Respondent's recognition of this error has led to a changed and improved practice in surgical pathology [T-250, 262].

Factual Allegation A.2. is not sustained.

20. There was no evidence presented regarding the diagnoses of four cervical biopsies contained in specimens B, C, D, and E [T-81-82, 95].

Factual Allegation A.3. is sustained.

21. On April 22, 1996, Respondent reviewed and reported on a cervical tissue specimen obtained from Patient A by means of a loop electro surgical excision procedure ("**LEEP**") (Department's Exhibits # 4 and # 9A, slide no. 96S2072 and # 22a, 22b, 22d, 22e, 22g, 22h); [T-52].

22. Respondent diagnosed condylomatous change, squamous metaplasia, and acute and chronic cervicitis in his April 22,1996 report of the specimen (Department's Exhibit # 4). Each of these diagnosis was present in the specimen [T-82, 84, 256].

23. Condylomatous change indicates changes in the cells in the squamous epithelium of the biopsy specimen. These are changes due to the human papilloma virus ("**HPV**"), including nuclear enlargement. A diagnosis of condylomatous change is not the same as a diagnosis of condyloma [T-253-254].

24. A diagnosis of condylomatous change is not a normal diagnosis and indicates to the treating physician that there is a need for follow-up of the patient [T-84, 264].

25. The April, 1996 specimen from Patient A, also, contained a small fraction of cells identified as adenocarcinoma [T-54].

26. Although squamous metaplasia was present in the April 1996 specimen, it was less clinically significant than the presence of the malignant cells. Although the April 1996 specimen contained inflammatory cells, these cells were directly adjacent to the adenocarcinoma, and the presence of cancer was the significant diagnosis to be reported [T-61-63].

27. Invasive adenocarcinoma of the cervix is an infrequent diagnosis, but one a reasonably prudent pathologist is expected to make. Failure to diagnose an invasive adenocarcinoma of the cervix is a deviation from minimally acceptable standards of medical care [T-63].

28. Respondent admitted that he misdiagnosed the April 1996 specimen. Respondent admitted that he failed to discern the invasive adenocarcinoma present there and that the cancer was the most clinically significant diagnosis [T-254, 262, 264, 276].

29. Patient A's cervical cancer was correctly diagnosed in December of 1996 by another pathologist (Department's Exhibit # 4); [T-89-90].

30. There was insufficient evidence to indicate that Patient A's adenocarcinoma was actually progressive as it could have been invasive from the beginning (Department's Exhibit # 4); [T-60].

PATIENT B

Factual Allegation B. is not sustained.

31. Factual Allegation B was withdrawn by the Department on December 12, 2001 [T-17-18].

PATIENT C

Factual Allegations C.1. and C.2. are not sustained.

32. On March 20, 1996 Respondent reviewed and reported on a cervical tissue specimen obtained from Patient C by means of an ECC procedure (Department's Exhibits # 8 and # 9, slide no. 96S1565C and # 28a through 28c); [T-128-129].

33. On March 20, 1996, Respondent issued a report diagnosing specimen C as "few minute fragments of unremarkable endocervical tissue product. Detached fragments of squamous epithelium with one tiny fragment showing cellular atypia." (Department's Exhibit # 8). Respondent's diagnosis accurately reflects what was present on the microscopic slide [T-305, 309].

34. The diagnosis identified what was present in the specimen and reflects that there was a small quantity of tissue being reported on. The mention of a finding of a small amount of endocervical epithelium indicates that the biopsy was taken from the correct area and justifies the diagnosis of "tiny fragments". The mention of one tiny fragment is sufficient to alert a reasonably prudent clinician that he or she should follow up with the patient and redo the procedure [T-139-141, 301-304].

35. It is incumbent on a pathologist to report on what he has before him [T-138, 305].

36. Respondent admitted that the specimen obtained from Patient C was less than he would "reasonably want" in reviewing a specimen [T-304]. In his current practice, Respondent would include a description of the tissue in his report to the clinician and add that the sample was "insufficient for further evaluation" [T-312-313].

37. Although the specimen was marginally inadequate (or marginally adequate), Respondent addressed that fact by indicating that he found "one tiny fragment". Patient C had other abnormalities, which dictated that a reasonably prudent clinician would continue close follow-up and

evaluation. The diagnosis made by Respondent with respect to Specimen C is not a deviation from minimally acceptable standards of medical care [T-311-314].

PATIENT D

Factual Allegation D. is not sustained.

38. On February 20, 1996 Respondent reviewed and reported on two cervical tissue specimens obtained from Patient D by means of a cervical biopsy and ECC (Department's Exhibits # 11 and # 9, slide nos. 96S0808A and # 29e through 29i); [T-144-145].

39. In his February 20, 1996 report, Respondent reported the presence of squamous metaplasia with koilocytotic atypia and chronic endocervicitis (Department's Exhibit # 11); [T-321-325, 331, 335-336).

40. Koilocytotic atypia is a term, which can be used to describe squamous epithelial cells showing changes that look like koilocytes, ie, have altered nuclei and perinuclear halos. The atypia was due to the cervicitis [T-326].

41. Respondent did not diagnose any dysplastic changes in specimen A. The term atypia is not synonymous with dysplasia [T-327-328].

42. The specimen slides for Patient D were reviewed by Respondent's senior pathologist, Dr. Hiroshi Nakazawa, at Enzo. Dr. Nakazawa agreed with Respondent's diagnosis and signed the report (Department's Exhibit # 11); [T-323-325].

43. Patient D had prior abnormal pap results, which would have dictated her cryosurgery. The diagnosis made by Respondent with respect to Patient D's specimens was not a deviation from minimally acceptable standards of medical care [T-143-154, 321-336].

PATIENT E

Factual Allegation E. is not sustained.

44. On March 18, 1996 Respondent reviewed and reported on a biopsy specimen obtained from Patient E's colon (Department's Exhibits # 13 and # 9, slide no. 96S1533B and # 32a, 32d, 32e, 32h); [T. 166].

45. Respondent reported a diagnosis and findings of a hyperplastic right colon polyp (specimen B) with severe chronic inflammation in the lamina propria and reactive atypia of the colonic crypts (Department's Exhibit # 13); [T-166, 338].

46. Patient E's biopsy specimen showed mostly adenomatous polyp with some features of a hyperplastic polyp [T-166, 192-193, 339-346].

47. Patient E's prior history would have dictated need for regular follow-up. The diagnoses made by Respondent with respect to Patient E's specimens was not a deviation from minimally acceptable standards of medical care [T-166, 174, 192-193, 339-357].

PATIENT F

Factual Allegation F.1. is not sustained.

48. Factual Allegation F.1. was withdrawn by the Department [T-196, 210].

Factual Allegation F.2. is not sustained.

49. On March 20, 1996 Respondent reviewed and reported on five specimens taken from Patient E by means of ECC and colposcopy (Department's Exhibit # 15).

50. As to specimen D Respondent diagnosed a condylomatous change with focal mild dysplasia (CIN I)[6]. As to specimen E Respondent diagnosed a condylomatous change

[6] Cervical Intraepithelial Neoplasia lesion.

(Department's Exhibits # 15 and # 16, slide nos. 96S1562D and 96S1562E and # 34b, 34e, 34f, 34g, 35a, 35c, 35d, 35e); [T-197-198, 206-207].

51. Respondent initially diagnosed specimen D as condylomatous change with focal mild to moderate dysplasia (CIN I to CIN II) (Department's Exhibit # 15 at page 7). After a review by Respondent's supervisor (and more experienced pathologist), Dr. Hiroshi Nakazawa, and discussion regarding the diagnosis for specimen D, Respondent amended his report to reflect Dr. Nakazawa's opinion of a condylomatous change with focal mild dysplasia (CIN I) (Department's Exhibit # 15); [T-359-361].

52. In specimen D, the difference between a CIN I and CIN II is a matter of interpretation, judgment, and subjective differences. The diagnosis made by Respondent with respect to specimen D from Patient F was not a deviation from minimally acceptable standards of medical care (Department's Exhibit # 15); [T-197-198, 205-206, 210-214, 357-365, 373-379].

Factual Allegation F.3. is not sustained.

53. In the context of the findings made by Respondent in specimen D, specimen E shows condylomatous changes. Specimen E contained morphologic changes that reflect the effect of the human papilloma virus, including an enlargement of the nuclei, nuclear membrane wrinkling, and cells that show a halo around the nucleus [T-206-209, 367-372].

54. Dr. Hiroshi Nakazawa reviewed the specimen and diagnosis made for specimen E. Dr. Nakazawa agreed with Respondent's diagnosis of condylomatous change and signed-off on the March 20, 1996 report (Department's Exhibit # 15); [T-367].

55. Patient F had prior abnormal pap results, which were suspicious and would have required regular follow-up by a reasonably prudent clinician. The diagnosis made by Respondent with respect to specimen E from Patient F was not a deviation from minimally acceptable standards of medical care (Department's Exhibit # 15); [T-206-209, 367-372].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Statement of Charges were by a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, contained in the November 9, 2001 Statement of Charges are **SUSTAINED:**[7]

Paragraphs A., A.1., A.3. : (9 - 19, 21 - 30)

The Hearing Committee concludes that the following Factual Allegations, contained in the November 9, 2001, Statement of Charges, are **NOT SUSTAINED:**

Paragraph A.2.	:	(20)
Paragraph B.	:	(31)
Paragraph C., C.1., C.2.	:	(32 - 37)
Paragraph D.	:	(38 - 43)
Paragraph E.	:	(44 - 47)
Paragraph F., F.1., F.2., F.3.	:	(48 - 55)

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee concludes that the FIRST SPECIFICATION contained in the Statement of Charges is **SUSTAINED**.

The Hearing Committee concludes that the SECOND SPECIFICATION contained in the Statement of Charges is **NOT SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

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[7] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support or negates each Factual Allegation contained in the Statement of Charges.

DISCUSSION

Respondent is charged with two specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct, which constitute professional misconduct. However, §6530 of the Education Law does not provide definitions or explanations of the types of misconduct charged in this matter.

The ALJ provided to the Hearing Committee suggested definitions of medical misconduct as alleged in this proceeding. These suggested definitions involve the practicing of the profession: (1) with negligence on more than one occasion; and (2) with incompetence on more than one occasion. The definitions used are as follows:

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

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

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated both witnesses for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee understood that as the trier of fact they may accept so much of a witnesses' testimony as is deemed true and disregard what is found to be false.

The Hearing Committee found Respondent to be very credible and qualified. Similarly the Hearing Committee found Dr. Goldstein, as the Department's expert, to be credible and very qualified. The differences between the testimony of the experts is more of form than substance.

Dr Goldstein presented well reasoned, definitive opinions of the microscopic slides he reviewed for the Department. Dr. Goldstein appears to view the practice of pathology as a "black and white" science. Respondent, Dr. Pulakhandam, appears to have the view, shared by many, that the practice of pathology is more of an art than a science. The Hearing Committee believes that there is room for judgment and interpretation. A pathologist cannot practice in a vacuum but at times must rely on information provided by the clinician. Other than the Patient A case, the diagnoses provided by Respondent are very interpretation dependent and have sufficient validity to be consistent with minimal standards of care, and in the context of the individual patients' care were relevant. The interpretations provided by Dr. Goldstein follow strict text book criteria, which may not take into account clinician information or local customs of practice.

Patient A

Respondent candidly admitted and conceded that his diagnoses of the specimens obtained from Patient A in March and April 1996 failed to include the more serious finding of adenocarcinoma. The failure to report the finding of adenocarcinoma in the March, 1996 report issued by Respondent was a deviation from minimal accepted standards of medical care. The failure to report the finding of adenocarcinoma in the April, 1996 report issued by Respondent was also a deviation from minimal accepted standards of medical care. Respondent was negligent in March 1996 and again in April 1996. Therefore, Respondent is guilty of committing professional misconduct by practicing the profession of medicine with negligence on more than one occasion. Respondent is guilty of violating Education Law §6530(3).

The Hearing Committee does not find that Respondent's actions as to Patient A indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of incompetence on any occasion. There was insufficient evidence that

Respondent lacked the skills necessary to perform the duties of a pathologist. Respondent is not guilty of violating Education Law §6530(5).

Respondent is also charged with misdiagnosing four cervical biopsies. No testimony was presented to support that allegation. Therefore, the Hearing Committee does not sustain that charge and allegation.

Patient B

The Factual Allegation as to Patient B was withdrawn by the Department.

Patient C

The allegations contained in the Statement of Charges related to Patient C involve the adequacy of the specimen reported on by Respondent. With regard to Patient C, Respondent reported on three specimens. Dr. Goldstein was critical of Respondent because he felt the amount of tissue in the third specimen was insufficient for diagnostic purposes. However, Dr. Goldstein admitted that it is a pathologist's duty to report on that which he has been given in the way of a specimen. Respondent's report sufficiently indicates to the clinician treating this patient that specimen C was scanty. Respondent notes that there are "a few minute fragments of unremarkable tissue." Those words clearly convey to the clinician that the specimen contained a small quantity of tissue.

Respondent, also, reported "detached fragments of squamous epithelium with one tiny fragment showing cellular atypia." Again, the words convey to the clinician that there is a very small piece of tissue that does not appear normal. There was presence of squamous epithelium, and Respondent properly reported on it. The microscopic slides were more accurate and the squamous epithelium was more prevalent on the microscopic slides than on the photographs taken by Dr. Goldstein.

The Hearing Committee believes that the reporting of specimen C was appropriate and sufficient to allow Patient C's physician to discern that the sample was scanty. The report issued by Respondent met minimally accepted standards of medical practice. Therefore, Respondent is not guilty of committing professional misconduct by practicing the profession of medicine with negligence or incompetence on more than one occasion. Respondent is not guilty of violating Education Law §6530(3) or §6530(5).

Patient D

Respondent and Dr. Goldstein were basically saying the same thing but using different words to convey their expert opinions. When Respondent referred to "atypia" in his report, he was not indicating that there were dysplastic changes present. Although Dr. Goldstein said the word "atypia" could be synonymous with dysplasia, Respondent described a difference between a finding of atypia and dysplastic changes. Respondent recognizes these as different processes with different changes in cells. He clearly did not identify any dysplastic changes in his reporting of Patient D.

In further support of Respondent's diagnoses, these specimens were reviewed and agreed to by the senior pathologist at Enzo. The slides were reviewed by Dr. Hiroshi Nakazawa, a senior pathologist working at Enzo. Dr. Nakazawa, an experienced and respected pathologist, agreed with and supported Respondent's diagnoses in this case.

The Hearing Committee believes that the reporting of the specimens was appropriate and that the report issued by Respondent met minimally accepted standards of medical practice. Therefore, Respondent is not guilty of committing professional misconduct by practicing the profession of medicine with negligence or incompetence on more than one occasion. Respondent is not guilty of violating Education Law §6530(3) or §6530(5).

Patient E

With regard to specimen B, Respondent diagnosed hyperplastic polyp with severe chronic inflammation in the lamina propia and reactive atypia of colonic crypts. Dr. Goldstein, likewise, found fragments of hyperplastic surface epithelium, or hyperplastic cells, but diagnosed an adenomatous polyp. The language in Respondent's report of reactive atypia of the colonic crypt could be interpreted as adenomatous change. Respondent described his findings on the photographic slides and pointed out why he diagnosed hyperplastic polyp with changes rather than adenomatous polyp.

Dr. Goldstein admitted that the follow-up on Patient E would not be significantly different whether there was a finding of a hyperplastic polyp or a finding of an adenomatous polyp. The diagnosis of an adenomatous polyp might not require any follow-up. In either case, it would be up to the clinician to determine the necessary follow-up for the patient. Dr. Goldstein also admitted that an adenomatous polyp in a patient with the clinical history of Patient E is of less import.

The Hearing Committee believes that the reporting of the specimens was appropriate and that the report issued by Respondent met minimally accepted standards of medical practice. Therefore, Respondent is not guilty of committing professional misconduct by practicing the profession of medicine with negligence or incompetence on more than one occasion. Respondent is not guilty of violating Education Law §6530(3) or §6530(5).

Patient F

Respondent originally diagnosed a CIN I to CIN II lesion. The handwriting on the working draft of the report states "condylomatous change with focal mild to moderate dysplasia (CIN I to CIN II)." However, Respondent's senior pathologist reviewed this diagnosis before issuing the

report and disagreed with the CIN II findings. Dr. Nakazawa's opinion was that there existed extensive condylomatous changes and that CIN II was higher than he would have reported. Dr. Nakazawa's opinion prevailed and the diagnosis was reported in the March 20, 1996 report as "condylomatous change with focal mild dysplasia (CIN I)." A review of the microscopic slides confirms that the difference between a CIN I and a CIN II is very subjective and a matter of interpretation and judgment based on experience and a myriad of other factors. Although a CIN II report would be more accurate, a CIN I report is not necessarily inappropriate in this context.

With regard to specimen E, in the context of the previous specimen, the microscopic slides do reflect condylomatous change. For example, the slides showed enlarged nuclei, showed nuclear membrane wrinkling, and had cells that showed a halo. The diagnosis was reviewed and confirmed by Dr. Nakazawa.

The Hearing Committee believes that the reporting of the specimens was appropriate and that the report issued by Respondent met minimally accepted standards of medical practice. Therefore, Respondent is not guilty of committing professional misconduct by practicing the profession of medicine with negligence or incompetence on more than one occasion. Respondent is not guilty of violating Education Law §6530(3) or §6530(5).

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above unanimously determines that NO PENALTY should be imposed on Respondent or Respondent's license to practice medicine in New York State.

§6530 of the Education Law indicates that a licensee found guilty of professional misconduct shall be subject to the penalties prescribed in §230-a of the P.H.L. P.H.L. §230-a

provides that "The penalties which may be (emphasis added) imposed by the state board for professional medical conduct on a present or former licensee found guilty of professional misconduct under the definitions and proceedings prescribed in section two hundred thirty of this title and sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law are:"

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service; (10) Probation and (11) Dismissal in the interest of justice.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. § 230-a. Since the statute states "may be imposed", the Hearing Committee has the power and authority to not impose a penalty if the Hearing Committee believes that to be appropriate. This case, the Hearing Committee believes, is the rare case in which no penalty should be imposed on Respondent even though we made a finding of professional misconduct.

In order to understand the Hearing Committee's reasoning, it is important to understand Respondent's experience in 1996 and the practice of pathology. As indicated in the above Findings of Fact (# 2 through # 5), Respondent was at the beginning of his career in the independent practice of high volume clinical/surgical pathology. Respondent did a standard four plus one year of pathology training. He then worked and obtained training in blood banking, a very different sub-speciality of pathology. Afterwards, he was away from the practice of pathology for a number of months for family reasons. In effect, Respondent was away from the practice of surgical pathology for almost two years. This absence created an extremely difficult problem to overcome. Even the best practitioner loses some acumen when not subjected to the daily repetitive regimen of his practice.

Respondent then started and completed a fellowship in anatomic pathology and became Board certified in clinical and anatomic pathology in May, 1995. Respondent began employment at Enzo Clinical Laboratories in January, 1996.

When Respondent began his employment at Enzo, we believe that Respondent was under the impression that he would have daily supervision and the ability to interact with his more experienced director/pathologist. Instead, Respondent was thrown into a high volume clinical situation where he had infrequent supervision or consultation with the experienced pathologist and was, in addition, given significant administrative duties. It took less than five months for Respondent to realize he was in over his head. All of the Charges and allegations contained in the Department's Statement of Charges occurred in the first few months of Respondent's employment at Enzo.

As to Patient A, Respondent made a serious mistake, which he admitted several times in the course of the Hearing. The Hearing Committee observed Respondent's demeanor as clearly indicating the pain he has suffered due to the mistake he made early on in his career. As to the other allegations, which we have not sustained, Respondent provided full detailed explanations of his reasoning at the time he reviewed and reported on the microscopic slides (specimens). Although we recognize and understand the criticism by the State's expert, Dr. Goldstein, we believe that in the context of the practice of clinical pathology, Respondent's diagnoses met minimally accepted standards of care.

One of the sanction recommendations made by the Department involves a requirement that Respondent practice pathology in a supervised setting and a practice monitor. The Hearing Committee believes that Respondent came to that conclusion when he left his (nearly) solo practice at Enzo in July, 1996 and began employment in a strongly supervised setting in December, 1996 as

a full-time attending pathologist at Nassau University Medical Center ("**Nassau University Hospital**"). Respondent has shown growth and improvement in the practice of pathology while at Nassau University Hospital. Respondent's awareness of the nuances of pathological reporting has increased and his reporting language, comments, and communication skills have all benefitted in the past five years. Therefore, we see no valid reason to impose the sanction of limiting Respondent to a supervised setting or to impose a practice monitor. The Hearing Committee is comfortable that the public is sufficiently protected even if no supervised sanction is imposed because we believe that Respondent is comfortable and capable in his setting at Nassau University Hospital and is not likely to move back to a solo practice. In addition to the supervision discussed above, Respondent benefits from the collegial interaction present at Nassau University Hospital, which was not present at Enzo.

The Hearing Committee, also, considered placing Respondent on probation, but believes that in effect, due to the highly supervised structure of Nassau University Hospital, Respondent has been on probation for the past five years in his present employment setting. Respondent testified that Nassau University Hospital has a quality assurance program that evaluates pathologists on a regular basis in monthly meetings and that he believes Nassau University Hospital has an excellent, program, which provides daily supervision and consultation. At Nassau University Hospital, two pathologists review frozen-section diagnoses, and all significant biopsies have to be reviewed in a departmental consultation meeting.

The Hearing Committee believes that suspension of Respondent's license, whether stayed or not, would serve no purpose other than to place Respondent's current and future employment in jeopardy. Given that the misconduct of negligence found by the Hearing Committee occurred six years ago, under mitigating circumstances, even the imposition of a censure and reprimand is seen by the Hearing Committee as unnecessary and potentially harmful to Respondent's continued

employment. In any event, the ongoing remorse that Respondent expresses due to his error (Patient A) has had a greater impact on Respondent than any censure and reprimand we could impose at this time. Importantly, this error had a profound effect on the Respondent's subsequent professional practices in regard to endocervical specimens, in handling other small diagnostic specimens, and in teaching resident physicians at Nassau University Hospital.

Respondent was asked about his current C.M.E. training. Respondent testified that Nassau University Hospital provides C.M.E. training which consist of monthly guest speakers in different areas of pathology, hospital-wide grand rounds, teleconference in the pathology area, anatomic as well as clinical. Nassau University Hospital has a residency program and staff pathologists are heavily involved in residents' teaching conferences, including surgical pathology, cytopathology, autopsy pathology, and other related topics. Lastly, Respondent is subject to a national performance improvement program at Nassau University Hospital. The Hearing Committee believes that Respondent should continue with his current C.M.E. training at Nassau University Hospital, and we recommend, as we would recommend to any physician, that Respondent consider attending national and international meetings to keep his skills up-to-date. Given the above, the Hearing Committee believes that to impose a sanction of additional medical training on Respondent is unnecessary.

The Hearing Committee believes that neither public service nor monetary penalties are appropriate sanctions under the circumstances presented in this case.

Respondent has requested that we dismiss the Charges in the interest of justice as authorized by §6530 of the Education Law. We have considered Respondent's request and deny that request. Insufficient reasons exist or have been presented to grant the unusual remedy of dismissal in the interest of justice. The Hearing Committee believes that the imposition of no

penalty is more appropriate under the circumstances of this case.

In assessing the appropriate penalty to be imposed on Respondent, the Hearing Committee has attempted to balance the misconduct, which we have found has occurred, against the circumstances of the misconduct, the mitigating factors presented by Respondent, the growth of Respondent since the misconduct, and the honesty and remorse shown by Respondent.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. The Hearing Committee concludes that there is no need to punish Respondent any further, no deterrence factor is involved due to the unique nature of the circumstances and that the public is appropriately protected by the Respondent's recognition of his problem, his education over the ensuing years and his current professional situation.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The FIRST SPECIFICATION contained in the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED**; and

2. The SECOND SPECIFICATION contained in the Statement of Charges (Department's Exhibit # 1) is **NOT SUSTAINED**; and

3. **NO PENALTY is IMPOSED** on Respondent or Respondent's license to practice medicine in the State of New York ; and

4. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
February, 15 **2002**

JERRY WAISMAN, M.D., (Chairperson)
PRAKASH C. SAHARIA, M.D.
REVEREND EDWARD J. HAYES

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APPENDIX I

Padmanabha Pulakhandam, M.D.

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

IN THE MATTER OF PADMANABHA PULAKHANDAM, M.D.	STATEMENT OF CHARGES

PADMANABHA PULAKHANDAM, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 22, 1990, by the issuance of license number 181746 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. With respect to Patient A, (patients are identified in the attached Appendix), Respondent failed to diagnose adenocarcinoma.

1. On or about March 13, 1996, Respondent misdiagnosed an endocervical curettage (hereinafter "ECC") as squamous metaplasia and chronic cervicitis.
2. On or about March 13, 1996, Respondent misdiagnosed four cervical biopsies, reporting two as koilocytotic atypia, one as koilocytotic atypia with acute and chronic endocervicitis and squamous metaplasia, and another as Condylomatous change.
3. On or about April 22, 1996, Respondent misdiagnosed a repeat cervical biopsy as condylomatous change with squamous metaplasia and acute and chronic cervicitis.

B. ~~With respect to Patient B, on or about March 20, 1996, Respondent made errors in diagnosis in that Respondent's report of a prostate biopsy diagnosed low grade intraepithelial neoplasia right prostate (PIN I) and high grade~~

WITHDRAWN
12-12-01
MPZ

~~intraepithelial neoplasia left side (PIN III).~~

C. With respect to Patient C, on or about March 20, 1996 Respondent's report of a colposcopy diagnosed mild cervical dysplasia.

1. Respondent erred in reading a specimen (Specimen C) that was inadequate for evaluation of the endocervical epithelium of this patient and made a diagnosis based on an inadequate slide.
2. Respondent failed to advise the clinician that the biopsy specimen was inadequate.

D. With respect to Patient D, on or about February 20, 1996, Respondent misdiagnosed a cervical biopsy and ECC in that he reported the presence of squamous metaplasia with koilocytic atypia and chronic endocervicitis.

E. With respect to Patient E, on or about March 19, 1996, Respondent's report of the March 15, 1996 biopsy of polyps of the right and left colon gave a diagnosis of hyperplastic right colon polyp which was a misdiagnosis.

F. With respect to Patient F, on or about March 27, 1996, Respondent's report of the March 18, 1996 biopsy of the cervix reflected misdiagnoses as follows:

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1. ~~Respondent misdiagnosed a condylomatous change in Specimen C.~~
2. Respondent misdiagnosed a condylomatous change with focal mild dysplasia (CIN I) in Specimen D.
3. Respondent misdiagnosed a condylomatous change in Specimen E.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2001) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A, ~~B~~, C, D, E and/or F, and their respective subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2001) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A, ~~B~~, C, D, E and/or F, and their respective subparagraphs.

DATED: November 9, 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Padmanabha Pulakhandam, M.D.

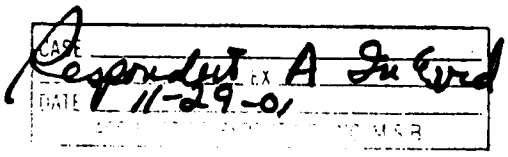
NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

PADMANABHA PULAKHANDAM, M.D.

ANSWER TO
STATEMENT OF CHARGES



Respondent PADMANABHA PULAKHANDAM, M.D., by his attorneys, Kern Augustine Conroy & Schoppmann, P.C., answers the Statement of Charges of the Bureau of Professional Medical Conduct as follows:

1. Admits that Respondent was authorized to practice medicine in New York State on or about March 22, 1990, by the issuance of License No. 181746 by the New York State Education Department.

2. Denies each and every allegation contained in the paragraphs of the Statement of Charges designated A., A.1, A.2, and A.3.

3. Denies each and every allegation contained in the paragraph of the Statement of Charges designated B.

4. Denies each and every allegation contained in the paragraphs of the Statement of Charges designated C., C.1. and C.2, except admits that Respondent issued a report dated March 20, 1996, regarding Patient C.

5. Denies each and every allegation contained in the paragraph of the Statement of Charges designated D.

6. Denies each and every allegation contained in the paragraph of the Statement of Charges

designated E.

7. Denies each and every allegation contained in the paragraphs of the Statement of Charges designated F., F.1., F.2. and F.3.

8. Denies each Specification of Charges designated FIRST through SECOND.

AS A FIRST AFFIRMATIVE DEFENSE

9. As provided for in the preface to Section 6530 of the New York State Education Law, the Charges and Specifications alleged in the Statement of Charges should be dismissed in the interest of justice.

WHEREFORE, Respondent prays for dismissal of the Statement of Charges and Specification of Charges in their entirety.

DATED: Lake Success, New York
November 20, 2001

KERN AUGUSTINE CONROY &
SCHOPPMANN, P.C.
Attorneys for Respondent

By: _____
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