NEW YORK
THE STATE OF LEARNING

OFFICE OF PROFESSIONAL MEDICAL CONDUCT

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

February 16, 1990

Humayun Rashid, Physician
129-04 Newport Avenue
Belle Harbor, N.Y. 11694

Re: License No. 139307

Dear Dr. Rashid:

Enclosed please find Commissioner's Order No. 10192. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Robert S. Asher, Esq.
295 Madison Avenue
New York, N.Y. 10017

REPORT OF THE
REGENTS REVIEW COMMITTEE

HUMAYUN RASHID

CALENDAR NO. 10192

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

HUMAYUN RASHID **No. 10192**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

HUMAYUN RASHID, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on April 12, April 13, May 19, May 23, May 24, June 16, June 17, August 2, September 15, October 4, and October 5, 1988 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the fifth and seventh specifications of the charges, and not guilty of the remaining charges. Paragraph F2 of the statement of charges was withdrawn at the hearing. The hearing committee recommended that respondent be Censured and Reprimanded and fined in the amount of $5,000.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions, and recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 2, 1989 respondent appeared before us in person and was represented by his attorney, Robert S. Asher, Esq., who presented oral argument on behalf of respondent. Paul R. White, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be Censured and Reprimanded and fined $5,000.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be Censured and Reprimanded with no fine.

We have considered the record as transferred by the Commissioner of Health in this matter.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 93 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted;
2. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
3. Respondent be found guilty, by a preponderance of the evidence, of the fifth and seventh specifications of the charges, and not guilty of the remaining charges; and
4. In partial agreement with the respondent, hearing committee, and Commissioner of Health, respondent be Censured and Reprimanded and fined $1,000 upon each specification of the charges of which we recommend respondent be found guilty, said fines to be imposed concurrently and total $1,000 and to be made payable, by certified check, to the order of the New York State Education Department, and mailed to the Executive Director, Office of Professional Discipline, New York

State Education Department, One Park Avenue, New York, New York 10016-5802 within 30 days after the effective date of the service of the order of the Commissioner of Education to be issued in this matter. In arriving at our recommendation as to the measure of discipline to be imposed, we have considered the circumstances herein, including but not limited to guilt having been found only with respect to two of the seven specifications regarding misconduct in 1984, as well as the differing recommendations as to the measure of discipline.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: December 20, 1989

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

IN THE MATTER	:	NOTICE
OF	:	OF
HUMAYUN RASHID, M.D.	:	HEARING

TO: HUMAYUN RASHID, M.D.
3701 Mermaid Avenue
Brooklyn, New York 11224

129-04 Newport Avenue
Belle Harbor, New York 11694

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney Supp. 1987) and N.Y. State Admin. Proc. Act §§301-307 (McKinney 1984 and Supp. 1988). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 12th and 13th days of April, 1988 at 10:00 a.m. in the forenoon of that day at 317 Washington Street, 11th Floor Conference Room 1, Watertown, New York 13601 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You

shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make a determination concerning what action should be taken with respect to your license to practice medicine in the State of New York.

Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide, at no charge, a qualified interpreter of the deaf to

interpret the proceeding to, and the testimony of, any deaf person.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney Supp. 1988), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. Pursuant to N.Y. Admin. Code Tit. 10, §51.5(c), an answer is required if there are affirmative defenses. Such answer shall be forwarded to the Division of Legal Affairs, Bureau of Professional Medical Conduct, New York State Department of Health, Tower Building, Room 2429, Empire State Plaza, Albany, New York 12237.

THESE PROCEEDINGS MAY RESULT IN A RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK EDUCATION LAW §6511 (McKINNEY 1985). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
March 16, 1988

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: PAUL R. WHITE
Associate Counsel

Telephone No.: (518) 473-7772

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
HUMAYUN RASHID, M.D.	:	CHARGES

----------X

HUMAYUN RASHID, M.D. , the Respondent, was authorized to engage in the practice of medicine in the State of New York on August 3, 1979 by the issuance of License Number 139307 by the State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 3701 Mermaid Avenue, Brooklyn, New York 11224 and 129-04 Newport Avenue, Belle Harbor, New York 11694.

FACTUAL ALLEGATIONS

A. On May 24, 1984, at approximately 4:00 p.m., the responsibility for Patient A's care (Patient A as well as all other patients are identified in Appendix A) at the Carthage Area Hospital in Carthage, New York was transferred to the Respondent. Later that day, between approximately 7:10 p.m. and 9:40 p.m., the Respondent was unavailable, and did not have

adequate medical coverage, to provide immediate medical care to Patient A.

B. On February 14, 1984, the Respondent admitted Patient B to The House of the Good Samaritan Hospital in Watertown, New York. Prior to this admission, Patient B had been receiving 22 units of NPH insulin and 10 units of regular insulin every morning.

1. The Respondent ordered 122 units of NPH insulin and 10 units of regular insulin on February 15, 1984.
2. The Respondent ordered 122 units of NPH insulin on February 16, 1984.
3. The Respondent ordered 117 units of NPH insulin on February 17, 1984.

C. On February 14, 1984, the Respondent inserted a temporary transvenous pacemaker for Patient C at the Mercy Hospital of Watertown. There was substantial blood loss during this procedure in which the Respondent made numerous attempts to introduce the pacemaker wire through the right femeral vein; Patient C subsequently received two units of packed red blood cells. On two occasions during the procedure the Respondent erroneously concluded that the pacemaker was properly positioned and pacing. The Respondent also ignored Patient C's complaints of chest pain.

D. On February 11, 1984, the Respondent inserted a temporary transvenous pacemaker for Patient D, who had sick sinus syndrome, at the Mercy Hospital of Watertown. The Respondent persisted in his attempt to introduce the pacemaker wire through

the right femeral vein for approximately fifty minutes before attempting a right subclavin approach. On his third right subclavin attempt, the Respondent was able to pass the pacer wire through the vein and into the heart after considerable blood loss. The Respondent then erroneously concluded that the pacer wire was properly positioned when, in fact, it was in the right atrium rather than the right ventricle. During the procedure, the Respondent told a nurse to give him a needle after it had dropped to the floor. Subsequently, on February 14, 1984, a permanent pacemaker was inserted; the Respondent's initial treatment of Patient D with a temporary pacemaker was inappropriate.

E. On January 10, 1984 the Respondent admitted Patient E to the Mercy Hospital of Watertown with a diagnosis of pneumonia.

1. The Respondent ordered two units of packed red blood cells transfused on January 20, 1984 in the absence of a clear medical indication.

2. Patient E had normocytic, normochromic anemia. The Respondent failed to order appropriate diagnostic tests to investigate the nature and cause of Patient E's anemia.

3. Patient E had hypoproteinemia, hypoalbuminemia and hyperglobulinemia. The Respondent failed to order appropriate diagnostic tests to investigate these serum protein abnormalities.

F. On January 10, 1984, the Respondent admitted Patient F to the Mercy Hospital of Watertown with a diagnosis of congestive heart failure.

1. The diagnosis of congestive heart failure was not adequately established.

2. The Respondent ordered Digoxin 0.25 mg daily for Patient F. Patient F's serum digoxin level was established on January 11, 1984 but was not subsequently evaluated during her ten day hospitalization.

3. The Respondent ordered diuretic therapy for Patient F without monitoring fluid loss and electrolyte balance.

4. The Respondent ordered two units of packed red blood cells transfused on January 17, 1984 in the absence of a clear medical indication.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE AND/OR

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession of medicine with negligence and/or incompetence on more than one occasion under N.Y. Educ. Law §6509(2) (McKinney 1985), in that the Petitioner charges:

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

SECOND THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

AND/OR GROSS INCOMPETENCE

The Respondent is charged with practicing the profession of medicine with gross negligence and/or gross incompetence

under N.Y. Educ. Law §6509(2) (McKinney 1985), in that, the Petitioner charges:

2. The facts in paragraph B.1, B.2 and B.3.

3. The facts in paragraph C.

4. The facts in paragraph D.

FIFTH SPECIFICATION

ABANDONING OR NEGLECTING A PATIENT

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) as he abandoned or neglected a patient in need of immediate professional care without making reasonable arrangements for the continuation of such care within the meaning of 8 NYCRR 29.2(a)(1) (1987) in that, the Petitioner charges:

5. The facts of paragraph A.

SIXTH AND SEVENTH SPECIFICATIONS

ORDERING EXCESSIVE TREATMENT

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) as he ordered excessive treatment not warranted by the condition of

the patient within the meaning of 8 NYCRR 29.2(a)(7) (1987) in that, the Petitioner alleges:

6. The facts of paragraph E.1.

7. The facts of paragraph F.4.

DATED: Albany, New York
March 16, 1988

Peter D. Van Buren

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

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

IN THE MATTER OF HUMAYUN RASHID, M.D.	**REPORT OF** **HEARING** **COMMITTEE**

TO: HONORABLE DAVID AXELROD, M.D.
COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK

The undersigned Hearing Committee (the Committee) consisting of Reverend Monsignor Edward J. Hayes, Chairperson, C. Frederick Peckham, M.D. and William D. Hoskin, M.D. was duly designated, constituted and appoint by the State Board for Professional Medical Conduct (the Board). Commencing with the June 16, 1988 hearing, W. Graham Knox, M.D. was substituted for C. Frederick Peckham, M.D. as a panel member. Marshall Jay Grauer, Esq. served as the Administrative Law Judge.

The hearing was conducted pursuant to the provisions of New York Public Health Law Section 230 and New York State Administrative Procedure Act Sections 301-307 to receive evidence concerning the charges that the Respondent has violated provisions of the New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above-captioned matter and makes a Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "B"

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	March 16, 1988
Hearing Dates:	April 12, 1988 April 13, 1988 May 19, 1988 May 23, 1988 May 24, 1988 June 16, 1988 June 17, 1988 August 2, 1988 September 15, 1988 October 4, 1988 October 5, 1988
Hearing locations:	400 Broome Street New York, New York 8 East 40th Street New York, New York 10 East 40th Street New York, New York Syracuse Airport Inn Syracuse, New York 317 Washington Street Watertown, New York
Date and location of deliberations held by Committee:	February 10, 1989 March 28, 1989 8 East 40th Street New York, New York
The State Board for Professional Medical Conduct appeared by:	Peter D. Van Buren, Deputy Counsel BY: Paul White, Esq. Staff Counsel Tower Bldg. - Empire State Plaza Albany, New York 12237

Respondent appeared by:	Robert Asher, Esq. 110 East 42nd Street New York, New York 10017
Respondent's Address:	3701 Mermaid Avenue Brooklyn, New York 11224
	129-04 Newport Avenue Belle Harbor, New York 11694

WITNESSES

FOR THE DEPARTMENT

LOUIS CHARLES BATISTA, II, M.D.	Physician board certified in surgery
RALPH J. MARRILLEY, JR., M.D.	Physician board certified in internal medicine
DEBORAH CHAMBERS	Registered nurse
MADONNA KNOWLES	Registered nurse
SUSAN PETERS	Registered nurse
GWEN ADAMS	Registered nurse
CATHERINE M. HOPPER	Registered nurse
ARSHAD SIDDIQUI, M.D.	Physician board certified in internal medicine

FOR THE RESPONDENT

PAMELA SHIRLEY	Director of medical records at Mercy Hospital
MULISM KAHN, M.D.	Senior surgeon at Carthage Hospital
SUTAN MAHMOOD IMDAD, M.D.	Obstetrician and gynecologist
MIRZA ASHRAF, M.D.	Physician board certified in internal medicine and cardiology

RONALD I. RYZOFF, M.D.	Physician board certified in surgery and thoracic surgery
JOHN BRULLMAN	Handwriting Analyst
SANFORD LEFF, M.D.	Physician board certified in internal medicine and cardiology
HUMAYUN RASHID, M.D.	Respondent
ARTHUR SAWITSKY, M.D.	Retired physician
EDITH TUCKER	Registered nurse; office manager employed by Respondent

SUMMARY OF CHARGES

Respondent, a duly licensed, practicing physician, is charged with professional misconduct within the meaning of N.Y. Education Law §6509(2) and 6509(9) (McKinney 1985) in that he practiced his profession with gross negligence and/or gross incompetence and that he practiced his profession with negligence and/or incompetence on more than one occasion; that he committed unprofessional conduct in that he abandoned or neglected a patient in need of immediate professional care without making reasonable arrangements for the continuation of such care within the meaning of 8 NYCRR 29.2(a)(1) (1987), and further, that he ordered excessive treatment not warranted by the condition of the patient within the meaning of 8 NYCRR 29.2(a)(7) (1987).

These charges relate to the treatment Respondent provided to six separate patients at the Carthage Area Hospital, Good

Samaritan Hospital and Mercy Hospital of Watertown during the period encompassed by January 10 through May 24, 1984.

PRELIMINARY FINDINGS

Respondent was licensed to practice medicine in the State of New York on August 3, 1979 and was issued license number 1393071222.

FACTUAL ALLEGATIONS

Paragraph "A"

> A. On May 24, 1984, at approximately 4:00 p.m., the responsibility for Patient A's care at the Carthage Area Hospital in Carthage, New York was transferred to the Respondent. Later that day, between approximately 7:10 p.m. and 9:40 p.m., the Respondent was unavailable, and did not have adequate medical coverage, to provide immediate medical care to Patient A.

FINDINGS

1. Respondent commenced practice at Mercy Hospital and Good Samaritan Hospital, both in Watertown, New York, in January of 1984. (p. 1126)

2. On May 24, 1984, Respondent had temporary, limited privileges at Carthage Area Hospital. (p. 882-882, 1236)

3. These privileges did not permit the Respondent to perform invasive procedures. (p. 883)

4. On May 24, 1984, Patient A, a 65 year old female, was admitted to the Carthage Area Hospital through its emergency room

with complaints of chest pain for three days and difficulty in breathing. This patient had a history of congestive heart failure and diabetes. (Exh. "7"- p. 2) (p. 759, 826-827)

5. At about 4:00 p.m. on May 24, 1984 the responsibility for the care of Patient A was transferred to the Respondent pursuant to the request of Dr. Kahn, a surgeon at the hospital. (Exh. "7" - p. 40) (p. 825)

6. Respondent commenced caring for this patient and issued orders pertaining to the patient's care at 4:20 p.m. and subsequently at 5:50 and 7:00 p.m. (Exh. "7" - p. 41) (p. 826)

7. During the evening, "A"'s condition deteriorated, and her temperature rose to 102.4°, her blood pressure rose, and she developed difficulty in breathing. (p. 760, 765, 777-778)

8. Nurse Hopper unsuccessfully tried to reach Respondent at 7:10 p.m. and 8:30 p.m. at his home telephone number. (Exh. "7"- p. 81) (p. 828-829, 834-837)

9. At approximately 7:45 p.m. on that evening, Dr. Rashid telephoned the hospital and spoke to a Ms. Gwen Adams, a registered nurse, at which time he advised that he would no longer provide care for Patient A. (p. 775)

10. Part of the evening of May 24, 1984 Respondent was at home, and another part of the evening Respondent was at his office at the hospital. (p. 1242-1243)

11. There was no beeper system at the hospital, and Respondent later told Dr. Imdad, shortly after 9:00 p.m., that he was unaware that anyone was attempting to reach him. (p. 909)

12. Respondent returned to the hospital with Dr. Imdad and resumed treating Patient A at about 9:55 p.m. (p. 835, 911) (Exh. "7" - p. 82)

13. Respondent was notified that his privileges at the hospital were terminated at approximately 10:00 p.m. on May 24, 1984. (p. 909, 911, 1249)

CONCLUSIONS

With respect to Charge "A", the Hearing Committee concludes as follows:

First Specification (Practicing With Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

Fifth Specification (Abandoning or Neglecting a Patient) - Sustained by a vote of 3-0.

The Committee concludes that the Respondent gave a correct narrative account of his whereabouts during the evening in question, and the fact that the nursing staff was unsuccessful in reaching him for a period of time does not support the conclusion that he made himself unavailable or that these acts constituted negligence, incompetence or misconduct of any kind.

However, the record shows that there came a time on the evening of May 24, 1984 that the Respondent telephoned and notified a nurse that he would not be caring for this patient any longer. The patient required immediate care, and the Respondent himself took no steps for the continuation of said care but left it up to the hospital staff. The Committee concludes that the

Respondent's conduct did constitute a violation of the regulations in that he abandoned a patient.

FACTUAL ALLEGATIONS

Paragraphs "B1", "B2" and "B3"

> B. On February 14, 1984, the Respondent admitted Patient B to The House of the Good Samaritan Hospital in Watertown, New York. Prior to this admission, Patient B had been receiving 22 units of NPH insulin and 10 units of regular insulin every morning.
>
> 1. The Respondent ordered 122 units of NPH insulin and 10 units of regular insulin on February 15, 1984.
>
> 2. The Respondent ordered 122 units of NPH insulin on February 16, 1984.
>
> 3. The Respondent ordered 117 units of NPH insulin on February 17, 1984.

FINDINGS

14. Patient B was a 73 year old male who was transferred to Good Samaritan Hospital from A. Barton Hepburn Hospital in Ogdensburg, New York on February 14, 1984 at approximately 3:00 p.m. (Exh. "6") (p. 687-688)

15. While Patient B was in A. Barton Hepburn Hospital, he was receiving daily 22 units of NPH insulin and 10 units of regular insulin subcutaneously. (Exh. "4, "5", "6") (p. 327, 705)

16. Patient B had a history of nonhealing ulcers on both feet, congestive heart failure and diabetes mellitus. (Exh. "5" - p. 4) (Exh. "6" - p. 13)

17. After transferring to Good Samaritan Hospital,

Respondent became "B"'s attending physician. (Exh. "6" - p. 11, 13) (p. 329, 688, 714)

18. When Respondent first took over the care of Patient B, he received a discharge summary, which, in part, indicated that Patient B had been receiving 122 units (instead of 22 units) insulin NPH subcutaneously. Respondent had not yet received the complete hospital records. (Exh. "6" - p. 1) (p. 857-860, 1293)

19. On February 15, 1984 Respondent ordered, and Patient B received, 122 units of NPH insulin and 10 units of regular insulin. (Exh. "6" - p. 95)

20. Patient B received orange juice at approximately 4:00 p.m. on February 15, 1984 to counteract lethargy caused by low blood sugar, and Respondent was notified. (Exh. "6" - p. 74) (p. 690-693)

21. A daily dose of 122 units of NPH insulin is high but not necessarily unusual. Certain patients with severe diabetes and ulcerated feet get larger doses of insulin. (p. 1296)

22. Respondent's expert testified that he had numerous patients receiving over 100 units of insulin a day and has, on occasion, administered 200 units per day. (p. 865, 874)

23. On February 16, 1984, the day after Patient B first received the 122 units of NPH insulin, Patient B's blood sugar of 72 was within normal range. (p. 1301-1302)

24. On February 16, 1984, Respondent dropped the 10 units of regular insulin but continued the 122 units of insulin NPH. (Exh. "6" - p. 74)

25. On February 17, 1984, Respondent reduced the insulin NPH to 117 units. (Exh. "6" - p. 75)

26. On February 17, 1984, a nurse reviewed the records from A. Barton Hepburn Hospital and noted the discrepancy in the NPH dosage, i.e. 122 versus 22 units, and verified via a phone call that the correct dosage should have been recorded at 22. (Exh. "6") (p. 703-706, 722)

27. Upon learning of this discrepancy, Respondent discontinued his earlier orders and proceeded to prescribe regular insulin coverage. (p. 706)

CONCLUSIONS

With respect to Charges "B1", B2" and "B3", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - All three charges not sustained by a vote of 3-0.

Second Specification (Practicing with Gross Negligence and/or Gross Incompetence) - All three charges not sustained by a vote of 3-0.

The Hearing Committee concludes that these charges were not sustained. There is no doubt in the mind of the Committee that the discharge summary received from A. Barton Hepburn Hospital indicated 122 units of NPH insulin. The record further shows that Patient B was in very poor condition from his diabetes and had intractable ulcers on his feet, which would require possible

amputation, all of which could suggest the need for high doses of insulin. The Committee does not conclude that Respondent was negligent or incompetent for continuing what appeared to be the previous dosage. The record shows that a dosage over 100, although not common, is not extraordinary. When the patient exhibited signs that the dosage may have been too high, the Respondent started to reduce the quantity. Although he may have erred by not reducing it in greater quantities, this judgment on the part of Respondent did not constitute negligence or incompetence.

FACTUAL ALLEGATIONS

Charge "C"

> C. On February 14, 1984, the Respondent inserted a temporary transvenous pacemaker for Patient C at the Mercy Hospital of Watertown. There was substantial blood loss during this procedure in which the Respondent made numerous attempts to introduce the pacemaker wire through the right femoral vein; Patient C subsequently received two units of packed red blood cells. On two occasions during the procedure the Respondent erroneously concluded that the pacemaker was properly positioned and pacing. The Respondent also ignored Patient C's complaints of chest pain.

FINDINGS

28. Patient C, a woman, 93 years of age, was admitted to Mercy Hospital on February 14, 1984 at 4:35 p.m. with a history of severe bradycardia, sick sinus syndrome, cardiomegaly, possible mild heart failure and diabetes mellitus. (Exh. "2"-1, 3) (p. 32)

29. Dr. Louis Batista, II admitted "C" to the hospital and

requested Respondent to evaluate this patient for a temporary pacemaker. (Exh. "2 - p. 38) (p. 33, 36)

30. It was determined that Patient C was a proper candidate for a temporary pacemaker, and at approximately 5:15 p.m. on February 14, 1984 she was taken to the fluoroscopy room and implant procedure was commenced by Respondent. (Exh. "2" - p. 76) (p. 33-34)

31. Respondent completed the procedure and inserted a temporary pacemaker in Patient C. (Exh. "2" - p. 2-7)

32. During the procedure Respondent made approximately six unsuccessful attempts to insert the pacing wire in the femoral vein before he was successful. (p. 425)

33. Because of the nature of the femoral vein, it can be difficult to locate readily for the purpose of inserting a pacing wire, and even though several attempts were necessary, Respondent's performance with within the framework of accepted medical practice. (p. 1689-1690)

34. The pacemaker was ultimately positioned properly, and the patient was pacing. (Exh. "2" - p. 7) (p. 15)

35. There was an unknown amount of blood lost during the procedure, which was estimated by Dr. Batista as 500 cc's. The blood loss was never precisely quantified by any special procedures, however. (p. 46, 91, 435)

36. It is very difficult to correctly estimate loss of blood with any degree of accuracy by looking at bandages and drapes. (p. 1596)

37. Patient C had a permanent pacemaker implanted by Dr. Batista at approximately 11:00 a.m. on February 16, 1984, which was two days after the insertion of the temporary pacemaker. (Exh. "2" - p. 56-59)

38. For the three days subsequent to February 14, 1984, there was a gradual drop in hemoglobin and hematocrit, which ultimately necessitated a blood transfusion on February 17, 1984. (Exh. "2" - p. 18) (p. 54, 56)

39. There was conflicting testimony on the record whether the procedures of temporary pacemaker vs. permanent pacemaker and the accompanying loss of blood from each procedure was the major contributing factor in the drop of hemoglobin and hematocrit. (p. 1608-1642)

40. During the course of the procedure of implanting the temporary pacemaker, there were moments during which the nurse in attendance and Respondent did not agree whether the pacemaker was properly positioned. Ultimately, the temporary pacemaker was positioned and pacing properly. (p. 429-431)

41. It is not unusual during the insertion of a temporary pacemaker that momentary errors can be made and discussion had as to whether a pacemaker is properly positioned and pacing. The most important thing is to be certain that it is properly positioned at the conclusion of the procedure. (p. 1690-1692)

42. There came a point in time at approximately 5:15 p.m. when Patient C complained of left anterior chest pain. (Exh. "2" - p. 76) (p. 492)

43. After the completion of the procedure, and at approximately 7:00 p.m., Patient C indicated she had no pain and that it had gone away. (Exh. "2" - p. 77)

44. Respondent indicated on the chart that Patient C had tolerated the procedure well. (Exh. "2") (p. 95)

45. Chest pain is normal during these procedures and can be attributable to a variety of things such as catheter movement, current and slow heart rate. (p. 63-64)

CONCLUSIONS

With respect to Charge "C", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

Third Specification (Practicing with Gross Negligence and/or Gross Incompetence) - Not sustained by a vote of 3-0.

The factual allegations in this charge allege several different acts and/or omissions. First, with respect to blood loss, there was a great deal of testimony in the record on this issue and whether the amount lost was significant or not, and whether the amount could be accurately determined without taking specific weights or measurements. The testimony indicates that the blood loss could vary from 100 to 500 cc's. The Committee does not believe the record sustains a conclusion by a preponderance of the evidence that the blood loss was so

significant as to constitute negligence or incompetence, nor does the record show that even if there was, in fact, an actual loss of 500 cc's of blood that that would be so extraordinary to support such a conclusion.

With respect to Respondent's initial unsuccessful attempts to locate the femoral vein, expert testimony indicated that it is not unusual for this to occur. Nor is it unusual during an insertion of a temporary pacemaker that momentary errors be made whether the wire is properly positioned and pacing.

The Respondent did not believe that the chest pain sustained by the patient was significant. The diagnosis appeared to be correct, and it appeared from the record that the patient did, indeed, tolerate the procedure well, and this fact was really not at issue between the expert witnesses.

FACTUAL ALLEGATIONS

Paragraph "D"

> D. On February 11, 1984, the Respondent inserted a temporary transvenous pacemaker for Patient D, who had sick sinus syndrome, at the Mercy Hospital of Watertown. The Respondent persisted in his attempt to introduce the pacemaker wire through the right femoral vein for approximately fifty minutes before attempting a right subclavian approach. On his third right subclavian attempt, the Respondent was able to pass the pacer wire through the vein and into the heart after considerable blood loss. The Respondent then erroneously concluded that the pacer wire was property positioned when, in fact, it was in the right atrium rather than the right ventricle. During the procedure the Respondent told the nurse to give him a needle after it had dropped to the floor. Subsequently, on February 14, 1984, a permanent

pacemaker was inserted; the Respondent's initial treatment of Patient D with a temporary pacemaker was inappropriate.

FINDINGS

46. Patient D was a woman, 78 years old, who was admitted to Mercy Hospital by Respondent on February 11, 1984 with a history of dizziness and weakness for one week and also bradycardia/tachycardia syndrome. (Exh. "3" - p. 4) (p. 147-148)

47. Patient D's heartrate initially was noted to be fluctuating from 70 to 125. (Exh. "3" - p. 4)

48. Thereafter in the emergency room, Patient D's heartrate was found to be fluctuating from 50 up as high as 120, and EKG strips subsequently indicated 65 to 112. (Exh. "3" - p. 15, 25, 26) (p. 151, 152, 159, 160, 725)

49. Respondent was able to observe on the monitor instability in the cardiac rhythm - bradycardia/tachycardia syndrome. (p. 1355)

50. The patient had a medical history of numerous episodes of syncope, sick sinus syndrome and had received recommendations in the past for implantation of a permanent pacemaker. (p. 1355)

51. Respondent determined that the patient should have a temporary pacemaker to be followed up the subsequent implantation of a permanent pacemaker. (p. 1356)

52. In part, Respondent's decision to put in a temporary pacemaker was based on the wide fluctuations in the patient's pulse, which was an indication of instability, and also based on the possibility that a cardiac emergency might arise at the

hospital at a time when a cardiologist was not available. Respondent further wished to stabilize the patient's condition preparatory to inserting a permanent pacemaker and to aid in determining the type of permanent pacemaker. (Exh. "3") (p. 165-166, 1379 to 1380)

53. If, in the judgment of the examining physician, a stable patient may become unstable, the placement of a temporary pacemaker is a reasonable medical decision. (p. 1138, 1168, 1169, 1175)

54. The Respondent personally examined Patient D, and he made a reasonable decision upon said examination to insert the pacemaker, in view of the fact that she exhibited signs that she may became unstable. (p. 152-153, 166, 1168)

55. Respondent initially attempted to insert the temporary pacemaker through the right femoral approach, and after approximately 45 minutes without success, he abandoned this approach and attempted the subclavian approach. (p. 539-540)

56. The time spent in the femoral approach was not unreasonable under the circumstances. (p. 1140)

57. The most important thing is to conclude the procedure with the pacemaker properly inserted, positioned and functioning. (p. 1143)

58. Ultimately, Respondent was successful in the subclavian approach. (p. 542)

59. During the procedure, Respondent first placed the wire in the right atrium instead of in the right ventricle. After

discussion with the nurse assisting him, the error was corrected. (p. 542)

60. It is not uncommon for there to be some temporary errors in determining the position of the wires nor is it unusual to have a discussion about same before the correct positioning is accomplished. (p. 1691-1692)

61. During the procedure, there came a time when a needle fell to the floor, and there was some dialogue about a needle between Respondent and the nurse in attendance. The nurse believed Respondent wanted her to pick up the needle so he could use same. (p. 543)

62. Respondent testified that he requested a needle, but not the needle on the floor. (p. 1367)

63. There is no testimony in the record indicating precisely what Respondent said to the nurse with reference to this needle. (p. 543)

64. Subsequently, a permanent pacemaker was successfully implanted in Patient D. (Exh. "3")

CONCLUSIONS

The Committee concludes that the factual allegations set forth in the Statement of Charges are only partially correct.

It is true that Respondent inserted in place a temporary pacemaker for Patient D on February 11, 1984. After successfully attempting the femoral approach, Respondent changed to the subclavian approach, and it is also correct that Respondent, at

one point during the procedure, erroneously concluded that the wire was properly positioned and pacing.

The Committee concludes that the Respondent made a reasonable medical judgment in determining that a temporary pacemaker was indicated for Patient D. The record supports that judgment, and the treatment was appropriate. Even the Department's expert conceded that personally examining the patient was important to making such a judgment.

The fact that Respondent first made an unsuccessful femoral attempt and thereafter had to change to a right subclavian approach is acceptable. Although admittedly there was a significant period of time that elapsed during the attempt at the femoral approach, it was within acceptable limits. Although there might have been some blood loss, the Hearing Committee does not conclude that it was so substantial and significant as to constitute misconduct.

Finally, it is the judgment of the Committee that the record does not support a conclusion that Respondent requested or intended to request the assisting nurse to retrieve an unsterile needle from the floor to be returned to him for his use in the procedure.

In summary, the vote of the Committee with respect to the various acts alleged in the factual statements is as follows:

a. The propriety of the determination to put in a temporary pacemaker, First Specification, not sustained by a vote of 2-1; Fourth Specification, not sustained by

a vote of 3-0.

b. The time taken in the femoral approach, First Specification, not sustained by a vote of 3-0; Fourth Specification, not sustained by a vote of 3-0.

c. The issue of the significant blood loss, First Specification, not sustained by a vote of 3-0; Fourth Specification, not sustained by a vote of 3-0.

d. The fact that the Respondent erroneously concluded at one point that the pacer wire was properly positioned in the patient, First Specification, not sustained by a vote of 3-0; Fourth Specification, not sustained by a vote of 3-0.

e. The issue of the Respondent requesting that an unsterile needle be picked up off the floor for use in the procedure, First Specification, not sustained by a vote of 2-1; Fourth Specification, not sustained by a vote of 3-0.

FACTUAL ALLEGATIONS

Paragraph "E1"

E. On January 10, 1984 the Respondent admitted Patient E to the Mercy Hospital of Watertown with a diagnosis of pneumonia.

1. The Respondent ordered two units of packed red blood cells transfused on January 20, 1984 in the absence of a clear medical indication.

FINDINGS

65. Patient E was a woman, 62 years of age, who was admitted to Mercy Hospital on January 10, 1984. (Exh. "8")

66. Patient E had a medical history of fever, cough, confusion and lethargy for a period of one week. (Exh. "8" - p. 3, 4)

67. Patient E showed signs of right upper lobe pneumonia (p. 220)

68. On January 20, 1984, Respondent ordered two units of packed red blood cells transfused into Patient E slowly over eight hours. (Exh. "8" - p. 12, 35) (p. 240)

69. Respondent gave the transfusion based upon the fact that Patient E had a 9.5 hemoglobin, shortness of breath, presence of nucleated RBC in the blood, indicating stress in the bone marrow. (p. 1527, 1528)

70. Expert testimony indicated that the transfusion was indicated based on anemia, sinus tachycardia, impaired cerebration due to lack of oxygen, and nucleoid red cells in the peripheral blood. (p. 1659-1660)

71. It was within good and acceptable standards to order the two units of packed blood cells. (p. 1660-1661)

CONCLUSIONS

With respect to Charge "E1", the Hearing Committee concludes as follows:

First Specification - (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0

Sixth Specification (Ordering Excessive Treatment)

- Not sustained by a vote of 3-0.

The record indicates that there was a clear medical indication for the transfusion of blood to this patient and further demonstrates that this procedure had a positive effect on the patient's progress. The patient was clearly anemic, as was indicated in part by her hemoglobin of 9.5 per centimeter.

FACTUAL ALLEGATIONS

Paragraphs "E2" and "E3"

> 2. Patient E had normocytic, normochromic anemia. The Respondent failed to order appropriate diagnostic tests to investigate the nature and cause of Patient E's anemia.
>
> 3. Patient E had hypoproteinemia, hypoalbuminemia and hyperglobulinemia. The Respondent failed to order appropriate diagnostic tests to investigate these serum protein abnormalities.

FINDINGS

72. Patient E did develop normochromic/normocytic anemia. (p. 227, 229-231, 1662)

73. Respondent ordered complete blood counts and blood chemistries. (p. 1663)

74. Respondent did not order a reticulocyte test or a haptoglobulin test. (p. 1663, 1672, 1673)

75. A bone marrow test was attempted by Respondent on or

about the 17th of January, 1984, but the lab reported inconclusive results. (p. 1522)

76. A Coombs test was performed as part of the transfusion procedures on January 20, 1984. (p. 1670-1671) (Exh. "8" - p. 12)

77. Respondent did perform the appropriate and necessary tests relative to Patient E's condition. (p. 261, 1663)

78. There is no evidence in the record that Patient E had hyperglobulinemia. (p. 260)

79. If Patient E had any indication of hypoproteinemia, it was borderline and not clinically significant. (p. 1663)

80. Patient E did not have hypoalbuminemia, and the tests revealed that the results were within normal limits. (p. 1664)

CONCLUSIONS

With respect to Charge "E2", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

With respect to Charge "E3", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

As above noted, the Committee concludes that the allegations that this patient had hypoalbuminemia and hyperglobulinemia were not sustained by the record. That further, any borderline indication of hypoproteinemia was not clinically significant. Consequently, there was nothing in the record to sustain the allegations of Paragraph "E3." With respect to Paragraph "E2", the record shows that the Respondent did order diagnostic tests to evaluate the nature and cause of Patient E's anemia. Although there may have been some additional tests available, the Committee concludes that the tests ordered were adequate, and Respondent's omission did not constitute misconduct.

FACTUAL ALLEGATIONS

Paragraph "F1"

> F. On January 10, 1984, the Respondent admitted Patient F to the Mercy Hospital of Watertown with a diagnosis of congestive heart failure.
>
> 1. The diagnosis of congestive heart failure was not adequately established.

FINDINGS

81. Patient F was a woman, 76 years of age, who was admitted to the Mercy Hospital on January 10, 1984 with complaints of shortness of breath on walking and swelling of the legs for the past six weeks. She had a medical history of congestive heart failure and diabetes mellitus. (p. 272-273) (Exh. "9" - p. 4)

82. Respondent made an initial diagnosis of congestive heart failure. (p. 273-274) (Exh. "9" - p. 2-4)

83. It was reasonable to make an initial diagnosis of congestive heart failure in a patient who has had a prior history of same and exhibits shortness of breath, rails on both bases of lungs, an S3 gallop, edema of the legs and sustained jugular venous pressure. (p. 289-290, 1727-1729)

CONCLUSIONS

With respect to Charge "F1", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

The record shows that the admitting diagnosis of congestive heart failure in this patient, given the medical history and spectrum of complaints and findings, was reasonable, and there appeared to be no disagreement between the expert testimony on either side. The admitting diagnosis was reasonable. The fact that subsequent tests did not substantiate this diagnosis is moot.

FACTUAL ALLEGATIONS

Paragraph "F2"

> 2. The Respondent ordered Digoxin 0.25 mg daily for Patient F. Patient F's serum digoxin level was established on January 11, 1984 but was not subsequently evaluated during her ten day hospitalization.

THIS CHARGE HAS BEEN WITHDRAWN

FACTUAL ALLEGATIONS

Paragraph "F3"

> 3. The Respondent ordered diuretic therapy for Patient F without monitoring fluid loss and electrolyte balance.

FINDINGS

84. Respondent ordered Lasix, a diuretic, on January 10, 1984, for this patient when she was admitted. The initial dosage was 40 mg in the morning and 20 mg in the evening, and this was increased on January 16, 1984 to 40 mg both in the morning and in the evening. (p. 274-275) (Exh. "9" - p. 22, 25)

85. Respondent did not have Patient F monitored during the course of diuretic therapy in connection with the intake or output of fluids, nor was the patient's weight taken regularly. (p. 275-277, 297, 299)

86. The appropriate way to monitor a patient on diuretic therapy would be to weigh the patient daily before breakfast and/or to keep track of intake and output. However, this procedure is not absolutely mandatory. (p. 276, 1736)

87. The patient's condition improved during her stay in the hospital from January 10, 1984 to January 20, 1984, and there were notations in the patient's chart indicating that the patient was voiding "sufficient" quantities of urine. (Exh. "9" - p. 2, 57-58)

CONCLUSIONS

With respect to Charge "F3", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

The factual allegations are sustained. The Respondent did order diuretics, and intake and output of fluid was not monitored. The record shows that this monitoring would have been appropriate and necessary to evaluate precisely the fluid exchange. It is the conclusion of the Committee, however, that in light of all of the circumstances, including the improvement of the patient and the overall monitoring of her condition, as hereinbefore noted in the Findings, the omissions of the Respondent did not constitute negligence and/or incompetence.

FACTUAL ALLEGATIONS

Paragraph "F4"

> 4. The Respondent ordered two units of packed red blood cells transfused on January 17, 1984 in the absence of a clear medical indication.

FINDINGS

88. A complete blood count performed on January 11, 1984 showed a hemoglobin of 11.8 and a hematocrit of 34.1. On January 17, 1984, a blood count showed a hemoglobin of 12.2 and hematocrit of 35.00. (p. 278, 283-284) (Exh. "9" - p. 12)

89. Patient F had clinical evidence of compromised left ventricular function. (p. 280)

90. Particularly in light of the complete blood count results, which demonstrated that Patient F was not anemic and did not require blood, there would be no medical indication for a blood transfusion, and in fact, it could be a risk to the patient. (p. 280-281)

91. On January 17, 1984, Respondent entered an order on patient's chart, "2 packs RBC type and crossmatch in 12 hours." (Exh. "9" - p. 25)

92. Patient F received a blood transfusion on January 18, 1984 based on that entry, and said transfusion was noted by Respondent in his discharge summary. (Exh. "9" - p. 2, 53)

93. Respondent denies that his entry in the records was intended to request a transfusion, but rather, it was simply a request to type and crossmatch blood within the next 12 hours. (p. 1568)

CONCLUSIONS

With respect to Charge "F4", the Hearing Committee concludes as follows:

First Specification (Practicing with Negligence and/or Incompetence) - Not sustained by a vote of 3-0.

Seventh Specification (Ordering Excessive Treatment) - Sustained by a vote of 3-0.

The Hearing Committee concludes the factual allegations are correct. There was testimony presented by both sides on the reasonable interpretation and significance of Respondent's entry in the records relative to the blood transfusion. The Committee concludes that it was Respondent's intent to order blood for the patient. The Committee does not conclude that the entry and order constitutes negligence and/or incompetence but does conclude, however, that the Seventh Specification has been sustained in that Respondent ordered excessive treatment.

RECOMMENDATIONS

The Committee has sustained Charge "A" - Fifth Specification - in that Respondent abandoned a patient and also has sustained Charge "F4" - Seventh Specification - ordering excessive treatment.

There were other instances where the Committee concluded that the Respondent made certain errors or omissions, but they were not serious enough to rise to the level of misconduct.

After reviewing the record and the Findings and Conclusions, the Committee recommends:

a. That Respondent be censured and reprimanded;

b. That a fine be assessed in the sum of $5,000.00 (Five Thousand Dollars).

DATED: May 23, 1989

Respectfully submitted,

Edward J. Hayes

REVEREND MONSIGNOR EDWARD J. HAYES,
Chairperson
C. Frederick Peckham, M.D.
William D. Hoskin, M.D.

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

IN THE MATTER	:	
OF	:	COMMISSIONER'S
HUMAYUN RASHID, M.D.	:	RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on April 12, April 13, May 19, May 23, May 24, June 16, June 17, August 2, September 15, October 4 and October 5, 1988. Respondent, Humayun Rashid, M.D., appeared by Robert Asher, Esq. The evidence in support of the charges against the Respondent was presented by Paul White, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact

EXHIBIT "C"

and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

Dated: Albany, New York
August 3 1989

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

HUMAYUN RASHID

CALENDAR NO. 10192

The University of the State of New York

IN THE MATTER

OF

HUMAYUN RASHID
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10192

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10192, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (January 17, 1990): That, in the matter of HUMAYUN RASHID, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 93 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact and conclusions be accepted;
2. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
3. Respondent is guilty, by a preponderance of the evidence, of the fifth and seventh specifications of the charges, and not guilty of the remaining charges; and
4. In partial agreement with the respondent, hearing committee, and Commissioner of Health, respondent be Censured and Reprimanded and fined $1,000 upon each specification of the charges of which respondent was

found guilty, said fines to be imposed concurrently and total $1,000 and to be made payable, by certified check, to the order of the New York State Education Department, and mailed to the Executive Director, Office of Professional Discipline, New York State Education Department, One Park Avenue, New York, New York 10016-5802 within 30 days after the effective date of the service of the order of the Commissioner of Education to be issued in this matter. In arriving at the measure of discipline to be imposed, the circumstances herein have been considered, including but not limited to guilt having been found only with respect to two of the seven specifications regarding misconduct in 1984, as well as the differing recommendations as to the measure of discipline;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 31st day of January, 1990.

Thomas Sobol

Commissioner of Education