STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF HARISH KUMAR SAHAI, M.D.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: HARISH KUMAR SAHAI, M.D.
3857 Mary Ellen Drive
Bemus Point, New York 14712

21 Porter Street
Jamestown, New York 14701

165 W. Fairmont Avenue
Lakewood, New York 14750

152 Foote Avenue
Jamestown, New York 14701

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr. P.H., Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by HARISH K. SAHAI, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Public Health Law Section 230(12), that effective immediately HARISH K. SAHAI, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Public Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Public Health Law Section 230, and N.Y. State Administrative Procedure Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 29th day of May, 2002 at 10:00 AM at the Radisson Airport Hotel, 4243 Genesee Street, Buffalo, New York 14225 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. 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 proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180 (518-402-0751), 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. 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 findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
May 17, 2002

ANTONIA C. NOVELLO, M.D., M.P.H., Dr. P.H.
Commissioner

Inquiries should be directed to:

Amy B. Merklen
Assistant Counsel
NYS Department of Health
Division of Legal Affairs
2509 Corning Tower
Albany, New York 12237-0032
(518) 486-1841

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

IN THE MATTER

OF

HARISH KUMAR SAHAI, M.D.

STATEMENT

OF

CHARGES

Harish Kumar Sahai, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 30, 1995 by the issuance of license number 199917 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients identified in Appendix A), a 36 year old male, from on or about June 22, 1999 until approximately October 11, 2001 at Respondent's office located at 21 Porter Street, Jamestown, New York (hereinafter "Respondent's office"). Respondent's care and treatment of Patient A failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient A.

2. Respondent diagnosed Patient A with migraine headaches, depression, anxiety and panic attacks without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, depression, anxiety and/or panic attacks.

4. Respondent prescribed Fiorinal with Codeine, Xanax, Vicoden and Valium for Patient A without adequate medical justification(s) and/or failed to document such justification(s).

5. Respondent prescribed Fiorinal with Codeine, Xanax, Vicoden and Valium in inappropriate amounts, dosage and/or frequency.

6. Respondent prescribed Valium and Xanax simultaneously without adequate medical justification(s) and/or explanation and/or failed to document such justification(s).

7. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient A.

B. Respondent provided medical care and treatment to Patient B, a 28 year old female, from on or about June 5, 2000 until approximately July 16, 2001 at Respondent's office. Respondent's care and treatment of Patient B failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient B.

2. Respondent diagnosed Patient B with migraine headaches, depression, anxiety and hypertension without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) Patient B for the diagnosis of migraine headaches, depression, anxiety and/or hypertension.

4. Respondent failed to adequately evaluate and/or failed to document Patient B's symptoms of heartburn, chest pain and/or history of sexual molestation.

5. Respondent prescribed Fiorinal with Codeine and/or Vicoden for Patient B without adequate medical justification(s) and/or failed to document such justification(s).

6. Respondent prescribed Fiorinal with Codeine and/or Vicoden in inappropriate amounts, dosage and/or frequency.

7. Respondent ordered an EKG for Patient B without adequate medical justification(s) and/or failed to document such justification(s).

8. Respondent failed to adequately evaluate and treat signs of domestic violence and/or trauma and/or failed to document such evaluation and treatment.

9. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient B.

C. Respondent provided medical care and treatment to Patient C, a 39 year old male, from on or about March 19, 2001 until approximately April 20, 2001 in Respondent's office. Respondent's care and treatment of Patient C failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient C.

2. Respondent diagnosed Patient C with migraine headaches, chronic back pain and/or hypertension without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, chronic back pain and/or hypertension.

4. Respondent prescribed Fiorinal with Codeine, Vicoden, Duragesic, Naratriptan and/or Norvasc for Patient C without adequate medical justification(s) and/or failed to document such justification(s).

5. Respondent prescribed Fiorinal with Codeine, Vicoden, Duragesic, Naratriptan and/or Norvasc in inappropriate amounts, dosage and/or frequency.

6. Respondent inappropriately prescribed Vicoden, Fiorinal with Codeine and Duragesic simultaneously without adequate medical justification(s) and/or explanation and/or failed to document such justification(s).

7. Respondent prescribed Naratriptan to Patient C without adequate instructions for use and warnings about side effects and/or failed to document such instructions.

8. Respondent ordered an EKG for Patient C without adequate medical justification(s) and/or failed to document such justification(s).

9. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient C.

D. Respondent provided medical care and treatment to Patient D, a 34 year old female, from on or about April 23, 1999 until approximately October 10, 2000 at Respondent's office. Respondent's care and treatment of Patient D failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient D.

2. Respondent diagnosed Patient D with migraine headaches and/or lower back pain without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches and/or lower back pain.

4. Respondent prescribed Fiorinal with Codeine for Patient D without adequate medical justification(s) and/or failed to document such justification(s).

5. Respondent prescribed Fiorinal with Codeine for Patient D in inappropriate amounts, dosage and/or frequency.

6. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient D.

E. Respondent provided medical care and treatment to Patient E, a 27 year old male, from on or about December 22, 1998 until approximately August 1, 2001 at Respondent's office. Respondent's care and treatment of Patient E failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient E.

2. Respondent diagnosed Patient E with migraine headaches, depression, anxiety and hypertension without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, depression, anxiety and/or hypertension.

4. Respondent failed to adequately evaluate and/or document Patient E's symptoms of alcoholism.

5. Respondent prescribed Fiorinal with Codeine, Inderol, Imitrex, Effexor, Xanax and/or Celexa for Patient E without adequate medical justification(s) and/or failed to document such justification(s).

6. Respondent prescribed Fiorinal with Codeine for Patient E in inappropriate amounts, dosage and/or frequency.

7. Respondent failed to adequately monitor Patient E's use of Imitrex.

8. Respondent ordered EKGs for Patient E without adequate medical justification(s) and/or failed to document such justification(s).

9. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient E.

F. Respondent provided medical care and treatment to Patient F, a 29 year old female, from on or about July 14, 2000 until approximately August 3, 2001 at Respondent's office. Respondent's care and treatment of Patient F failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient F.

2. Respondent diagnosed Patient F with migraine headaches, depression, anxiety and panic attacks without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, depression, anxiety and/or panic attacks.

4. Respondent prescribed Fiorinal with Codeine and/or Xanax for Patient F without adequate medical justification(s) and/or failed to document such justification(s).

5. Respondent prescribed Fiorinal with Codeine and/or Xanax for Patient F in inappropriate amounts, dosage and/or frequency.

6. Respondent ordered an EKG and TSH for patient F without adequate medical justification(s) and/or failed to document such justification(s).

7. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient F.

G. Respondent failed to maintain a medical record in a manner that Respondent provided medical care and treatment to Patient G, a 33 year old female, from on or about September 14, 1999 until approximately July 7, 2000 at Respondent's office. Respondent's care and treatment of Patient G failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient G.

2. Respondent diagnosed Patient G with migraine headaches, depression, panic attacks and/or an acute LS sprain and hip sprain without adequate medical justification(s) and/or failed to document such justification(s).

3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, depression, panic attacks and/or an acute LS sprain and hip sprain.

4. Respondent prescribed Fiorinal with Codeine, Flexeril, Darvocet, Vicoden ES and/or Celexa for Patient G without adequate medical justification(s) and/or failed to document such justification(s).

5. Respondent prescribed Fiorinal with Codeine, Davocet and/or Vicoden ES for Patient G in inappropriate amounts, dosage and/or frequency.

6. Respondent ordered an EKG for Patient G without adequate medical justification(s) and/or failed to document such justification(s).

7. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient G.

H. Respondent provided medical care and treatment to Patient H, a 28 year old female, from on or about March 22, 1999 until approximately March 20, 2002 at Respondent's office. Respondent's care and treatment of Patient H failed to meet accepted medical standards, in that:

1. On various occasions, Respondent failed to obtain and/or document an adequate medical history for Patient H.
2. Respondent diagnosed Patient H with migraine headaches, depression, anxiety and/or acne without adequate medical justification(s) and/or failed to document such justification(s).
3. Respondent failed to adequately perform and/or failed to document an evaluation(s), treatment(s) and/or referral(s) for the diagnosis of migraine headaches, depression, anxiety and/or acne.
4. Respondent prescribed Fiorinal with Codeine for Patient H without adequate medical justification(s) and/or failed to document such justification(s).
5. Respondent prescribed Fiorinal with Codeine for Patient H in inappropriate amounts, dosage and/or frequency.
6. Respondent ordered an EKG for patient H without adequate medical justification(s) and/or failed to document such justification(s).
7. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient H.

I. Respondent provided medical care and treatment to Patient I, an 86 year old female, from on or about August 8, 1997 until approximately January 19, 1998 at The Woman's Christian Association Hospital, Jamestown, New York (hereinafter "WCA") and Respondent's office located at Access Medical Care, 165 West Fairmont Avenue, Jamestown, New York. Respondent's care and treatment of Patient I failed to meet accepted medical standards, in that:

1. On or about October 4, 1997, Patient I was admitted to WCA Hospital. Respondent failed to document Patient I's admission history and physical in a timely manner.
2. On or about October 4, 1997, Patient I was admitted to WCA Hospital. Respondent failed to perform and/or document a review of systems for Patient I.

3. On or about October 4, 1997, Patient I was admitted to WCA Hospital. Respondent failed to document Patient I's discharge summary in a timely manner.

4. On various occasions, Respondent failed to adequately evaluate and/or treat and/or document Patient I's condition when she presented with occult blood in her stool.

5. On various occasions, Respondent failed to adequately manage Patient I's Coumadin therapy and/or document such management.

6. On or about September 26, 1997, Respondent ordered Insulin and C peptide levels without adequate medical justification(s) and/or failed to document such justification(s).

7. Respondent inappropriately prescribed Naprosyn for Patient I.

8. Respondent diagnosed Patient I with hypoglycemia without adequate medical justification(s) and/or failed to document such justification(s).

9. Respondent failed to adequately evaluate and/or treat and/or document such evaluation and/or treatment for the diagnosis of hypoglycemia.

10. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient I.

J. Respondent provided medical care and treatment to Patient J, an 84 year old male, from on or about September 16, 1997 until approximately December 11, 1997at WCA Hospital. Respondent's care and treatment of Patient J failed to meet accepted medical standards, in that:

1. Upon Patient J's various admissions to WCA hospital, Respondent failed to document Patient J's medical history and physical examination in a timely manner.

2. Upon Patient J's various admissions to WCA Hospital, Respondent failed to adequately perform and/or document in a timely manner a review of systems.

3. Respondent diagnosed Patient J with pneumonia and anemia of chronic disease without adequate medical justification(s) and/or failed to document such justification(s).

4. Respondent failed to adequately evaluate, treat and/or refer Patient J for the diagnosis of pneumonia and anemia of chronic disease and/or failed to document same.

5. On or about November 10, 1997, Respondent inappropriately doubled Patient J's dosage of Levothyroxine (Synthroid) despite Patient J's history of tachycardia.

6. On or about November 11, 1997, Respondent recorded a DNR in Patient J's chart without a completed "advance directives" to indicate how and/or why the decision was reached.

7. Respondent failed to order and/or perform medically indicated laboratory tests and/or document such tests.

8. On or about November 8, 1997, Respondent failed to review the EKG and/or failed to document such review.

9. Respondent failed to maintain a record for Patient J in a manner that accurately reflected his care and treatment of Patient J.

K. Respondent provided medical care and treatment to Patient K, an 67 year old male, from on or about September 27, 1997 until approximately December 17, 1997 at WCA Hospital and Respondent's office located at Access Medical Care, 165 West Fairmont Avenue, Jamestown, New York. Respondent's care and treatment of Patient K failed to meet accepted medical standards, in that:

1. On or about September 30, 1997, Patient K was admitted to WCA Hospital. Respondent failed to document Patient K's medical history and physical examination in a timely manner.

2. On or about September 30, 1997, Respondent recorded contradictory information regarding Patient K's condition in Patient K's office chart and/or Patient K's hospital chart.

3. On or about September 30, 1997, Respondent ordered a vascular surgeon consultation without adequate medical justification(s) and/or failed to document such justification(s).

4. Respondent failed to adequately manage Patient K's anticoagulant and/or failed to document such management.

5. On or about October 1, 1997, Respondent ordered tests without adequate medical justification(s) and/or failed to document such justification(s).

6. On or about October 5, 1997, Respondent continued Patient K's hospitalization without adequate medical justification(s) and/or failed to document such justification(s).

7. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient K.

L. Respondent provided medical care and treatment to Patient L, an 37 year old male, from on or about June 18, 1997 until approximately March 3, 1998 at WCA Hospital and Respondent's office located at Access Medical Care, 165 West Fairmont Avenue, Jamestown, New York. Respondent's care and treatment of Patient L failed to meet accepted medical standards, in that:

1. On or about July 2, 1997, Respondent inappropriately referred Patient L to an otolaryngologist.

2. On various occasions, Respondent prescribed medication for Patient L that was contraindicated.

3. On or about September 23, 1997, Patient L was admitted to WCA Hospital. Respondent failed to document Patient L's medical history and physical examination for Patient L in a timely manner.

4. On or about September 23, 1997, Respondent failed to perform a review of systems and/or failed to document such review.

5. On or about September 23, 1997, Respondent failed to accurately document Patient L's allergy to penicillin in Patient L's hospital chart.

6. On or about September 23, 1997, upon admission to WCA Hospital, Respondent failed to record Patient L's recent Otitis Media condition.

7. On or about September 23, 1997, Respondent failed to order medically indicated tests before starting Patient L on antibiotics.

8. Between on or about September 28, 1997 and approximately October 6, 1997, Respondent ordered four (4) chest X-rays for Patient L without adequate medical justification(s) and/or failed to document such justification(s).

9. On or about September 28, 1997, Respondent inappropriately continued Patient L's hospitalization without adequate medical justification(s) and/or failed to document such justification(s).

10. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient L.

M. Respondent provided medical care and treatment to Patient M, a 71 year old male, from on or about November 14, 1997 until approximately November 29, 1997 at WCA Hospital. Respondent's care and treatment of Patient M failed to meet accepted medical standards, in that:

1. Upon Patient M's admission to WCA Hospital, Respondent failed to perform an adequate history and/or document such history.

2. On or about Patient M's admission to WCA, Respondent failed to obtain vital signs and/or failed to document such.

3. On or about Patient M's admission to WCA, Respondent failed to adequately evaluate the jugular veins and/or failed to document such evaluation.

4. During Patient M's hospitalization, Respondent failed to accurately describe the condition of Patient M's lungs.

5. Respondent recorded "bilateral pleural effusions" without adequate medical justification(s) and/or failed to document such justification(s).

6. Respondent failed to adequately manage Patient M's beta-blocker and/or failed to document such.

7. Respondent inappropriately discontinued Patient M's telemetry.

8. On or about November 14, 1997, Respondent failed to order and/or failed to document ordering a daily INR for Patient M despite adequate medical justification(s) to do so.

9. On or about November 14, 1997 and November 15, 1997, Respondent failed to discontinue and/or failed to document discontinuing Corgard despite medical justification(s) to do so.

10. On or about November 14, 1997, Respondent failed to order a cardiologist consult, despite adequate medical justification(s) to do so.

11. Respondent failed to maintain a medical record in a manner that accurately reflected his care and treatment of Patient M.

SPECIFICATIONS

FIRST THROUGH THIRTEENTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) 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. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6 and/or A7.
2. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8, and/or B9.
3. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.
4. The allegations in paragraphs D, D1, D2, D3, D4, D5 and/or D6.
5. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, E7, E8 and/or E9.
6. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6 and/or F7.
7. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6 and/or G7.
8. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6 and/or H7.
9. The allegations in paragraphs I, I1, I2, I3, I4, I5, I6, I7, I8, and/or I9.
10. The allegations in paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8, and/or J9.

11. The allegations in paragraphs K, K1, K2, K3, K4, K5, K6, and/or K7.

12. The allegations in paragraphs L, L1, L2, L3, L4, L5, L6, L7, L8, L9, and/or L10.

13. The allegations in paragraphs M, M1, M2, M3, M4, M5, M6, M7, M8, M9, M10, and/or M11.

FOURTEENTH THROUGH TWENTY-SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) 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:

14. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6 and/or A7.

15. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.

16. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.

17. The allegations in paragraphs D, D1, D2, D3, D4, D5 and/or D6.

18. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, E7, E8 and/or E9.

19. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6 and/or F7.

20. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6 and/or G7.

21. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6 and/or H7.

22. The allegations in paragraphs I, I1, I2, I3, I4, I5, I6, I7, I8, and/or I9.

23. The allegations in paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8, and/or J9.

24. The allegations in paragraphs K, K1, K2, K3, K4, K5, K6, and/or K7.

25. The allegations in paragraphs L, L1, L2, L3, L4, L5, L6, L7, L8, L9, and/or L10.

26. The allegations in paragraphs M, M1, M2, M3, M4, M5, M6, M7, M8, M9, M10, and/or M11.

TWENTY-SEVENTH THROUGH THIRTY-NINTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

27. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, and/or A7.

28. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.

29. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.

30. The allegations in paragraphs D, D1, D2, D3, D4, D5 and/or D6.

31. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, E7, E8 and/or E9.

32. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6 and/or F7.

33. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6 and/or G7.

34. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6 and/or H7.

35. The allegations in paragraphs I, I1, I2, I3, I4, I5, I6, I7, I8, and/or I9.

36. The allegations in paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8, and/or J9.

37. The allegations in paragraphs K, K1, K2, K3, K4, K5, K6, and/or K7.

38. The allegations in paragraphs L, L1, L2, L3, L4, L5, L6, L7, L8, L9, and/or L10.

39. The allegations in paragraphs M, M1, M2, M3, M4, M5, M6, M7, M8, M9, and/or M10.

FORTY THROUGH FIFTY-SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

40. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6, and/or A7.

41. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.

42. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.

43. The allegations in paragraphs D, D1, D2, D3, D4, D5 and/or D6.

44. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, E7, E8 and/or E9.

45. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6 and/or F7.

46. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6 and/or G7.

47. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6 and/or H7.

48. The allegations in paragraphs I, I1, I2, I3, I4, I5, I6, I7, I8, and/or I9.

49. The allegations in paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8, and/or J9.

50. The allegations in paragraphs K, K1, K2, K3, K4, K5, K6, and/or K7.

51. The allegations in paragraphs L, L1, L2, L3, L4, L5, L6, L7, L8, L9, and/or L10.

52. The allegations in paragraphs M, M1, M2, M3, M4, M5, M6, M7, M8, M9, and/or M10.

FIFTY-THREE THROUGH SIXTY-FIFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

53. The allegations in paragraphs A, A1, A2, A3, A4, A5, A6 and/or A7.

54. The allegations in paragraphs B, B1, B2, B3, B4, B5, B6, B7, B8 and/or B9.

55. The allegations in paragraphs C, C1, C2, C3, C4, C5, C6, C7, C8 and/or C9.

56. The allegations in paragraphs D, D1, D2, D3, D4, D5 and/or D6.

57. The allegations in paragraphs E, E1, E2, E3, E4, E5, E6, E7, E8 and/or E9.

58. The allegations in paragraphs F, F1, F2, F3, F4, F5, F6 and/or F7.

59. The allegations in paragraphs G, G1, G2, G3, G4, G5, G6 and/or G7.

60. The allegations in paragraphs H, H1, H2, H3, H4, H5, H6 and/or H7.

61. The allegations in paragraphs I, I1, I2, I3, I4, I5, I6, I7, I8, and/or I9.

62. The allegations in paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8, and/or J9.

63. The allegations in paragraphs K, K1, K2, K3, K4, K5, K6, and/or K7.

64. The allegations in paragraphs L, L1, L2, L3, L4, L5, L6, L7, L8, L9, and/or L10.

65. The allegations in paragraphs M, M1, M2, M3, M4, M5, M6, M7, M8, M9, M10, and/or M11.

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Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct