New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D.,M.P.H., Dr. P.H.
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NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

William P. Dillon, M.D.
Chair

Denise M. Bolan, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

July 29, 2002

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Harish Kumar Sahai, M.D.
3587 Mary Ellen Drive
Bemus Point, New York 14712

RE: License No. 199917

Dear Dr. Kumar Sahai:

Enclosed please find Order #BPMC 02-231 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect July 29, 2002.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Richard S. Tubiolo, Esq.
Hirsch and Tubiolo
1000 Reynods Arcade Building
16 East Main Street
Rochester, New York 14614-1796

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

IN THE MATTER
OF
HARISH KUMAR SAHAI, M.D.

SURRENDER ORDER

BPMC No. 02-231

Upon the application of Harish Kumar Sahai, M.D. to surrender his NYS medical license, which is made a part of this Surrender Order, it is

ORDERED, that the Surrender Order, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Surrender Order, either by first class mail to Respondent at the address in the attached Surrender Order or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, Whichever is first.

SO ORDERED.

DATED: 7/26/02

William P. Dillon, MD

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

HARISH KUMAR SAHAI, M.D.

SURRENDER

OF

LICENSE

Harish Kumar Sahai, M.D., representing that all of the following statements are true, deposes and says:

That on or about June 30, 1995, I was licensed to practice as a physician in the State of New York, and issued License No. 199917 by the New York State Education Department.

My current address is 3587 Mary Ellen Drive, Bemus Point, New York, 14712, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with sixty-five (65) specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I plead guilty to Specifications 1, 2, 11, 12, 14, 15, 24, 25, 53, 54, 63, and 64, in full satisfaction of the charges against me, and agree to the following penalty:

Surrender of New York Medical License

I understand that if the Board does not adopt this Surrender Order, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

Harish Kumar Sahai

Harish Kumar Sahai, M.D.
RESPONDENT

DATED July 9, 2002

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 7/9/02

RICHARD TUBIOLO, ESQ.
Attorney for Respondent

DATE: 7/12/02

AMY B. MERKLEN, ESQ.
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 7/25/02

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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.

DATED: May 17, 2002
Albany, New York

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

EXHIBIT "B"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE FOLLOWING A REVOCATION, SURRENDER OR SUSPENSION (of 6 months or more) OF A MEDICAL LICENSE

1. Respondent shall immediately cease and desist the practice of medicine in compliance with the terms of the Surrender Order. Respondent shall not represent himself or herself as eligible to practice medicine and shall refrain from providing an opinion as to professional practice or its application.

2. Within fifteen (15) days of the Surrender Order's effective date, Respondent shall notify all patients that he or she has ceased the practice of medicine, and shall refer all patients to another licensed practicing physician for their continued care, as appropriate.

3. Within thirty (30) days of the Surrender Order's effective date, Respondent shall have his or her original license to practice medicine in New York State and current biennial registration delivered to the Office of Professional Medical Conduct (OPMC) at 433 River Street Suite 303, Troy, NY 12180-2299.

4. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within thirty (30) days of the Surrender Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate contact person, acceptable to the Director of OPMC, who shall have access to these records. Original records shall be retained for patients for at least six (6) years after the last date of service, and, for minors, at least six (6) years after the last date of service or three (3) years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall ensure that all patient information is kept confidential and is available only to authorized persons. When a patient or authorized representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or sent at reasonable cost to the patient (not to exceed seventy-five cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of inability to pay.

5. Within fifteen (15) days of the Order's effective date, if Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall advise the DEA in writing of the licensure action and shall surrender his or her DEA controlled substance certificate, privileges, and any used DEA #222 U.S. Official Order Forms Schedules 1 and 2, to the DEA.

6. Within fifteen (15) days of the Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Controlled Substances of the New York State Department of Health. Respondent shall have all prescription pads bearing Respondent's name destroyed. If no other licensee is providing services at his practice location, Respondent shall dispose of all medications.

7. Within fifteen (15) days of the Order's effective date, Respondent shall remove from the public domain any representation that Respondent is eligible to practice medicine, including all related signs, advertisements, professional listings whether in telephone directories or otherwise, professional stationery or billings. Respondent shall not share, occupy or use office space in which another licensee provides health care services.

8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered (by himself or others) while barred from practicing medicine. Respondent may receive compensation for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and Respondent's license is revoked, surrendered or suspended for six (6) months or more pursuant to this Order, Respondent shall, within ninety (90) days of the Order's effective date, divest himself/herself of all financial interest in such professional services corporation in accordance with New York Business Corporation Law. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within ninety (90) days of the Order's effective date.

10. Failure to comply with the above directives may result in civil or criminal penalties. Practicing medicine when a medical license has been suspended, revoked or annulled is a Class E Felony, punishable by imprisonment for up to four (4) years, under Section 6512 of the Education Law. Professional misconduct may result in penalties including revocation of the suspended license and/or fines of up to $10,000 for each specification of misconduct, under Section 230-a of the Public Health Law.