STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

October 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gitesh Aggrawal, M.D.
119 Highlan Avenue, No.1K
Ossining, New York, 10029

Paul Stein, Esq
NYS Dept. of Health
5 Penn Plaza - Sixth Floor\
New York, New York 10001

Harvey B. Savitt, Esq.
353 Veteran's Memorial Highway
Commack, New York 11725

RE: In the Matter of Gitesh Aggrawal, M.D.

Dear Dr. Aggrawal, Mr. Stein and Mr. Savitt:

Enclosed please find the Determination and Order (No. 94-118) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler (H)

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

GITESH AGGRAWAL, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-118

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on September 30, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) July 21, 1994 Determination finding Dr. Gitesh Aggrawal (Respondent) guilty of professional misconduct. The Office of Professional Medical Conduct (Petitioner) and the Respondent requested the Review through Notices which the Board received on July 29, 1994 and August 8, 1994. James F. Horan served as Administrative Officer to the Review Board. Paul Stein, Esq. filed a brief for the Petitioner on August 9, 1994 and a reply brief on September 20, 1994. Harvey B. Savitt , Esq. filed a brief for the Respondent on September 12, 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall

be based upon a majority concurrence of the Review Board

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing with Gross Negligence, Gross Incompetence, Negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records. The charges arise from the care which the Respondent, an anesthesiologist, provided to two patients, whom the record refers to as Patients A and B.

By votes of two to one on each charge, the Hearing Committee sustained the charges that the Respondent was guilty of gross negligence and gross incompetence. The Committee unanimously sustained the charges that the Respondent was guilty of negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records. In the case of Patient A, the Committee found that the Respondent had failed to take proper procedures to protect Patient A's functioning lung from spillage during a procedure on the Patient's other lung. The Committee found that the spillage of purulent material into the Patient's functioning left lung was highly contributory to Patient A's inadequate pulmonary ventilation and death. In the case of Patient B, the Patient had gone into cardiac arrest during an obstetric procedure in which she was under anesthesia and the Patient died the following day. The Committee found that the Respondent had been unable to perform satisfactorily when faced with an adverse situation involving Patient B and had contributed to Patient B's death. The Committee found that the Respondent had extubated the Patient prematurely, failed to ventilate the Patient adequately, failed to immediately intubate the Patient, had transported the Patient without supplemental oxygen or monitoring, failed to sedate the Patient as suggested by the attending obstetrician-gynecologist and had administered the narcotic antagonist Narcan to Patient B. The Committee also found that the Respondent failed to maintain adequate records for Patient B.

The Hearing Committee ordered that the Respondent undergo the Phase I Evaluation at the Physician Prescribed Education Program (PPEP) at Syracuse. The Committee provided that if the Phase I Evaluation found that the Respondent was a candidate for re-education, the Respondent should undergo PPEP Phase II retraining. The Committee provided that if the Evaluation revealed that

the Respondent was not a candidate for re-education, that the case would be remanded to the Hearing Committee. The Committee provided that the Respondent's license would be suspended until the Respondent successfully completes retraining, except to the extent necessary for retraining, or until further Order of the Hearing Committee.

REQUESTS FOR REVIEW

The Petitioner urges the Review Board to sustain the Hearing Committee's penalty, except the Petitioner asks the Review Board to modify the program for any retraining, to provide that if the Respondent is a candidate for re-education, she must enter a retraining program of the New York State Society of Anesthesiology or a comparable program. The Petitioner points out that there is no PPEP Phase II retraining in anesthesiology.

The Respondent challenges the Findings of the Hearing Committee in the cases of Patients A and B. The Petitioner asserts that the Findings concerning Patient A were based on material from outside the record and that the Findings on Patient B were questionable because the Petitioner did not produce the Mortality and Morbidity Report and because the findings of the Medical Examiner clearly established that anesthesia management was not a contributing factor in Patient B's death. The Respondent requests that the Review Board vacate the Findings as to both Patients.

The Respondent requests, that if the Review Board sustains the Findings, that the Review Board modify the Hearing Committee's Penalty to remove the suspension from the Respondent's license during the retraining period. The Respondent brief asserts that the patients involved in this proceeding were extraordinary in nature and should not be the predicate to suspend the Respondent's license. The Respondent does not object, if the Review Board sustains the Hearing Committee's Findings, to the modification in the retraining terms that the Petitioner has recommended.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion and failure to maintain adequate records. The Determination is consistent with the Committee's Findings that the Respondent had failed to take proper steps in protecting Patient A's functioning lung and had not performed satisfactorily in the adverse situation involving Patient B, which contributed to Patient B's death.

The Review Board sustains in part and modifies in part the Hearing Committee's Penalty. The Review Board sustains the Hearing Committee's Determination to order the Respondent to undergo the Phase I PPEP Evaluation at Syracuse, the Committee's Determination that the Respondent undergo retraining if the PPEP Evaluation indicates that she is a candidate for re-education, the Hearing Committee's Order remanding the case to them if the Respondent is not a candidate for re-education and the Committee's Order suspending the Respondent's license during retraining. We modify the terms of the retraining, because there is no PPEP retraining in Anesthesiology.

Findings that the Respondent was guilty of repeated gross acts of negligence and incompetence are serious enough in nature to require a Penalty as severe as revocation or permanent limitation of the Respondent's license. The Review Board finds, however, that the two cases involved in this proceeding were quite difficult , and we accept the Hearing Committee's judgement that the Respondent should be offered a chance to correct her judgement and skills if she can demonstrate that she is a candidate for re-education. Public Health Law Section 230-a provides that a Hearing Committee may suspend a Respondent's license until such time as the Respondent completes a course of retraining. The Review Board finds that the suspension of the Respondent's license during retraining is appropriate in this case due to the serious nature of the sustained charges. The Review Board also finds that it is appropriate to remand this case to the Hearing Committee in the event that the PPEP Phase I Evaluation concludes that the Respondent is not a candidate for retraining. The Hearing Committee should then make a new Determination concerning an appropriate Penalty. Either party may then request an Administrative Review of the new Penalty within fourteen days from the receipt of the Hearing Committee's new Penalty Determination.

The Review Board modifies the retraining portion of the Committee's Penalty, because the PPEP Phase II retraining does not offer a program in anesthesiology. The Review Board orders, that if the Phase I Evaluation concludes that the Respondent is a candidate for retraining, the Respondent shall undergo the retraining in a program of the New York State Society of Anesthesiology or a comparable retraining program, at the discretion of the Director of the Office of Professional Medical Conduct.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **sustains** the Hearing Committee on Professional Medical Conduct's July 21, 1994 Determination that Dr. Gitesh Aggrawal was guilty of professional misconduct.

2. The Review Board **sustains** the Hearing Committee's Determination ordering Dr. Aggrawal to undergo a PPEP Phase I Evaluation, and to undergo retraining program in anesthesiology if the Phase I Evaluation concludes that Dr. Aggarwal is a candidate for retraining.

3. The Review Board **sustains** the Hearing Committee's Determination suspending Dr. Aggrawal's license to practice medicine during the retraining period.

4. If the PPEP Evaluation concludes that Dr. Aggrawal is not a candidate for retraining, the Review Board **remands** this case to the Hearing Committee for a new Determination on the Penalty.

5. The Review Board **modifies** the Hearing Committee's Penalty to provide that the Respondent shall undergo retraining in a program of the New York State Society of Anesthesiology, or a comparable program, at the discretion of the Director of the Office of Professional Medical Conduct.

ROBERT M. BRIBER
SUMNER SHAPIRO
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF GITESH AGGARWAL, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Aggarwal.

DATED: Albany, New York

October 18, **1994**

ROBERT M. BRIBER

IN THE MATTER OF GITESH AGGARWAL, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Aggarwal.

DATED: Delmar, New York

Oct 26, **1994**

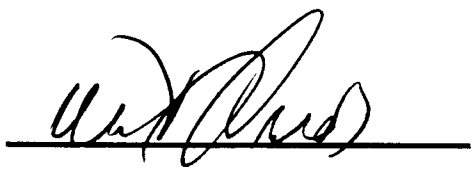
SUMNER SHAPIRO

IN THE MATTER OF GITESH AGGARWAL, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Aggarwal.

DATED: Brooklyn, New York

_____, 1994



WINSTON S. PRICE, M.D.

IN THE MATTER OF GITESH AGGARWAL, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Aggarwal.

DATED: Roslyn, New York
October 21, **1994**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF GITESH AGGARWAL, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Aggarwal.

DATED: Syracuse, New York
14 Oct **, 1994**

William A Stewart

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

July 21, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gitesh Aggarwal, M.D.
119 Highland Avenue, No. 1K
Ossining, New York 10562

Paul Stein, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Harvey B. Savitt
353 Veteran's Memorial Highway
Commack, New York 11725

RE: In the Matter of Gitesh Aggarwal, M.D.

Dear Dr. Aggarwal, Mr. Savitt and Mr. Stein :

Enclosed please find the Determination and Order (No. 94-118) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER	:	HEARING COMMITTEE
OF	:	DETERMINATION
GITESH AGGARWAL, M.D.	:	AND ORDER
		NO. BPMC-94- 118

Stephen A. Gettinger, M.D., Chairperson, Erwin Lear, M.D., and Terri L. Weiss, Esq., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. Stephen Bermas, Esq., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	March 31, 1994
Statement of Charges dated:	March 31, 1994
Hearing Dates:	May 3, May 10 and June 7, 1994
Deliberation Date:	July 6, 1994

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Paul Stein, Esq.
Respondent Appeared By:	Harvey B. Savitt, Esq.

STATEMENT OF CHARGES

The Statement of Charges has been marked as Petitioner's Exhibit 1 and hereto attached as Appendix A.

CREDIBILITY OF WITNESSES

The Hearing Committee found Dr. Aaron Kopman to be a credible witness. However, some of his testimony was questionable because of his reliance in part on material that was outside of the medical records of the patients involved in the charges in this proceeding.

Lorraine Anlyan, CNRA, was found to be credible but she had no direct knowledge of the issues involved in this proceeding.

Dr. Gitesh Aggarwal was not found to be very credible even as to clinical facts. Her answers often were evasive and not responsive to the questions posed to her. Furthermore, she did not have the impartiality necessary to be considered an expert witness.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of cited evidence.

1. Respondent was authorized to practice medicine in New York State on May 13, 1983 by the issuance of license number 154076 by the New York State Education Department. (Ex. 2)

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. (Ex. 2)

Patient A

3. On October 5, 1987, Respondent administered anesthesia to Patient A, a 29 year old female, during an attempted open drainage of a right empyema and closure of a right bronchopulmonary fistula, at Queens Hospital Center, 82-68 164th Street, Jamaica, New York. The empyema and fistula developed following a right pneumonectomy, for drug resistant tuberculosis, performed on July 20, 1987. (T. 36-38, Ex. 3 at 136-39)

4. Patient A died on October 5, 1987 in the post-anesthesia care unit. (T. 42, Ex. 3 at 203r (reverse))

5. Patient A's preoperative diagnosis was "right bronchopleural fistula with empyema". (T. 38-39, Ex. 3 at 138)

6. A cardiothoracic physician's note signed by the attending surgeon, Dr. Nkongho, dated 10/4/87, 9:00 a.m., in the progress notes of Patient A's chart, states "current diagnosis of post pneumonectomy broncho-pleural fistula with multiloculated empyema. This has to be evacuated by open drainage since it is loculated. This would warrant an anesthetic technique with special caution to avoid spillage to contralateral functioning lung." (Ex. 3 at 100r)

7. A medical clearance note dated 10/4/87 in the progress notes of Patient A's chart states that she had a "bronchopleural fistula". (Ex. 3 at 101r)

8. Respondent had primary responsibility to protect Patient A's functioning lung from spillage. (T. 45-46)

9. The most reliable way of protecting Patient A's functioning lung from spillage would have been to employ a double lumen endotracheal tube. (T. 46)

10. A left-sided double lumen endotracheal tube has a short right half and long left half. The long left half goes past the bifurcation of the trachea and the tip of the left half rests in the left main stem bronchus. On the tip of the left half is a balloon that can be blown up. When that balloon is inflated, the left lung may be ventilated independently of the right chest, and even if there is spillage from the right pleural cavity, into the trachea, it will not pass the balloon and enter the left main stem bronchus. (T. 47, Ex C)

11. Respondent failed to isolate Patient A's left lung from the fistula. (T. 44-48)

12. Respondent failed to employ a double lumen tube for the initial intubation. (T. 46-47, Ex. 3 at 203)

13. Respondent was unaware of the fact that Patient A had a broncho-pleural fistula. (T. 237, 296-7)

14. Had Respondent known that Patient A had a broncho-pleural fistula, she would have used a double lumen endotracheal tube. (T. 219, 223)

15. Respondent failed to turn Patient A to a supine position and a steep Trendelenberg position when spillage of empyema material began. (T. 49-50, Ex. 3 at 203)

16. Before the incision was made, Respondent noticed empyema material coming from Patient A's endotracheal tube. During the procedure, it was necessary to suction the tube several times, and 2-3 changes of breathing circuit tubing were made due to the drainage of empyema material. (T. 39-41, 49-50, 270-1, Ex. 8 at 4)

17. The empyema material was purulent. (T. 46)

18. The spillage of purulent material into Patient A's left lung was highly contributory to Patient A's inadequate pulmonary ventilation and death. (T. 56)

19. Respondent failed to consider switching from a single lumen to a double lumen endotracheal tube after Patient A was under anesthesia. (T. 291)

20. Respondent failed to insert a double lumen tube or employ a bronchial blocker when spillage of empyema material began. (T. 52-55, Ex. 3 at 203)

21. Respondent failed to order a halt to the operative procedure in the face of continuing spillage of empyema material. (T. 52-54, 61-62, 96-97)

22. Respondent failed to keep an adequate record for Patient A. (T. 56, 57, 60, 113, Ex 3 at 203)

23. Among the information that Respondent failed to record on Patient A's chart is the following:

(a) at what time was the patient turned into the lateral position;
(b) when was bronchoscopy performed;
(c) was bronchoscopy performed to check the tube position;
(d) when was the first evidence of spillage; and
(e) in view of the marked degrees of respiratory acidosis, failed to indicate ventilation parameters employed, such as minute volume, PEEP pressures, and respiratory rate. (T. 57)

24. Respondent's anesthesia record for Patient A was written in such a way that it is impossible to put together a logical sequence of what took place. (T. 59-60)

Patient B

25. On November 25, 1989, during an elective tubal ligation, at Queens Hospital Center, 82-68 164th Street, Jamaica, New York, Respondent administered anesthesia to Patient B, an obese 39 year old female with a history of hypertension. Patient B

went into cardiac arrest in the post-anesthesia care unit. (T. 116-118, Ex. 4 at 9)

26. Patient B died on November 26, 1989 in the surgical intensive care unit. (T. 148, 329, Ex. 4 at 9)

27. Respondent's actions were a substantial contributing factor to Patient B's death. (T. 149-150)

28. Patient B extubated herself twice following the surgery. (T. 121-123, Ex. 4 at 10, Ex. A at 1)

29. Respondent prematurely extubated Patient B. (T. 128-30, 174-75)

30. Respondent failed to ventilate adequately Patient B following the surgical procedure. (T. 133-35, 175-55, 184)

31. There was a prolonged period of inadequate ventilation. (T. 134-35)

32. Respondent failed immediately to reintubate Patient B when she was noted to be unresponsive upon arrival in the post-anesthesia care unit. (T. 130-31)

33. Respondent transported Patient B from the operating room back to the recovery room without supplemental oxygen or monitoring. (T. 149-50, 379, Ex. 8 at 2, Ex. 4 at 5)

34. During the second intubation, Dr. Amy Levine, the attending obstetrician-gynecologist, suggested to Respondent that she keep the patient intubated to ensure adequate oxygenation, even if this might require muscle paralysis. (Ex. 4 at 9r)

35. Respondent failed to sedate Patient B or administer a dose of muscle relaxant sufficient to paralyze her, following two incidents of Patient B extubating herself. (T. 130-33, 179, Ex. 4 at 9, 10, Ex. A at 1)

36. Respondent administered the narcotic antagonist Narcan (naloxone) to Patient B. (T. 122-23, 125-26, 130, 346, Ex. 4 at 5, 9, 10, Ex. A at 1)

37. Respondent ordered the Narcan for Patient B. (T. 346)

38. Patient B did not have eclampsia (T. 183-84)

39. Respondent failed to keep an adequate record for Patient B, including, but not limited to, failing to record Patient B's vital signs and oxygen saturations during the initial post extubation period, and failing to record a coherent post-

anesthesia note. (T. 146-48, 173-74, 377, 384-85, Ex. 4 at 5, 10)

40. Respondent failed to record Patient B's vital signs for at least a half hour period, between the hours of approximately 11:30 a.m. and 12:00 noon, when the patient had been reintubated because of ventilatory difficulties and hypoxia. (T. 377, 146-47, Ex. 4 at 5)

41. When faced with an adverse situation involving Patient B, Respondent was unable to perform satisfactorily. (T. 348-9)

CONCLUSIONS

All Conclusions are unanimous except when otherwise indicated.

FIRST: Respondent is found by a two to one vote of the Hearing Committee to have engaged in professional misconduct by reason of practicing medicine with gross negligence with respect to Patients A and B, within the meaning of N.Y. Education Law Section 6530(4)(McKinney Suppl. 1994), as set forth in Findings of Fact 3 through 41, supra.

SECOND: Respondent is found by a two to one vote of the Hearing Committee to have engaged in professional misconduct by reason of practicing medicine with gross incompetence

with respect to Patients A & B, within the meaning of N.Y. Education Law Section 6530(6)(McKinney Suppl. 1994), as set forth in Findings of Fact 3 through 41, supra.

THIRD: Respondent is found to have engaged in professional misconduct by reason of practicing medicine with negligence on more than one occasion with respect to Patients A and B within the meaning of N.Y. Education Law Section 6530(3) (McKinney Suppl. 1994), as set forth in Findings of Fact 3 through 41, supra.

FOURTH: Respondent is found to have engaged in professional misconduct by reasons of practicing medicine with incompetence on more than one occasion with respect to Patients A and B within the meaning of N.Y. Education Law Section 6530(5) (McKinney Suppl. 1994), as set forth in Findings of Fact 3 through 41, supra.

FIFTH: Respondent is found to have engaged in professional misconduct by reason of failing to maintain records for Patient A and for Patient B which accurately reflect the evaluation and treatment of said patients, within the meaning of N.Y. Education Law Section 6530(32) (McKinney Suppl. 1994), as set forth in Findings of Fact 22, 23, 24, 39 and 40.

ORDER

The Hearing Committee determines and orders that Respondent submit to a Phase I evaluation by the Physician Prescribed Education Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center at Syracuse.

If the Phase I evaluation indicates that Respondent is a candidate for re-education, then the Respondent must enter into Phase II of the PPEP.

If the Phase I evaluation indicates that Respondent is not a candidate for re-education, this matter shall be remanded to this hearing Committee for further action.

The Respondent's license to practice medicine shall be suspended until the Office of Professional Medical Conduct determines that she has completed successfully Phase II of the PPEP or until further order of this Hearing Committee. In the interim, Respondent's license shall be restored partially to the extent necessary to permit her to participate in Phase II.

Dated: New York, N.Y.
July 19, 1994

Stephen A. Gettinger, M.D.
Chairperson

Erwin Lear, M.D.
Terri L. Weiss, Esq.

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

Petitioner's 1
In Evidence
@ 5-3-94

IN THE MATTER OF

Gitesh Aggarwal, M.D.

AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
COUNTY OF New York) SS:

Albert Baldassarri, being duly sworn, states:

1. I am over eighteen years of age and am not a party to the above captioned proceeding.

2. I am employed by the New York State Department of Health's Office of Professional Medical Conduct as a Sr. Medical Conduct Investigator.

3. I served the annexed Notice Of Hearing, Statement Of Charges & Summary Of Department Of Health Hearing Rules upon Gitesh Aggarwal, M.D. by going to 119 Highland Avenue, NO. 1K Ossining, N.Y. on April 5, 19 94, at approximately 5:25 PM ~~XXXX~~ p.m. and handing said person a true copy thereof.

4. A description of the person so served is as follows:

Approx. Age: 41yrs; Approx. Weight: 145lbs; Approx. Height: 5'5";
Sex: Female Skin Color: Brown; Hair Color: Brown;
Other identifying characteristics: _____

Albert Baldassarri
Signature

DAVID K. TRENARY
Notary Public, State of New York
No. 31-4718432
Qualified in New York County
Commission Expires May 31 1994

Sworn to before me
on this 6 TH day of
April, 19 94

David K. Trenary
NOTARY PUBLIC

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

IN THE MATTER	
OF	NOTICE
GITESH AGGARWAL, M.D.	OF
	HEARING

TO: Gitesh Aggarwal, M.D.
119 Highland Avenue, No. 1K
Ossining, New York 10562

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 3rd and 10th days of May, 1994, at 9:30 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 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 issue or 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 and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (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.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. 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.

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 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 THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
March 31, 1994

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: Paul Stein
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2605

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

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IN THE MATTER	:	STATEMENT
OF	:	of
GITESH AGGARWAL, M.D.	:	CHARGES

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GITESH AGGARWAL, M.D., the Respondent, was authorized to practice medicine in New York State on May 13, 1983 by the issuance of license number 154076 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994.

FACTUAL ALLEGATIONS

A. On or about October 5, 1987, Respondent administered anesthesia to Patient A (Patient A and all other patients are identified in the attached appendix), a 29 year old female, during an attempted open drainage of a right empyema and closure of a right bronchopulmonary fistula, at Queens Hospital Center, 82-68 164th Street, Jamaica, New York. The empyema and fistula developed following a right pneumonectomy, for drug resistant tuberculosis, performed on July 20, 1987. Patient A died on October 5, 1987 in the post-anesthesia care unit.

1. Respondent inappropriately failed to isolate Patient A's good lung from the fistula.

2. Respondent inappropriately failed to employ a double lumen tube for the initial intubation.

3. Respondent inappropriately failed to turn Patient A to a supine orientation in a steep Trendelenberg position when massive spillage of empyema material began.

4. Respondent inappropriately failed to insert a double lumen tube or employ a bronchial blocker when massive spillage of empyema material began.

5. Respondent inappropriately failed to order a halt to the operative procedure in the face of continuing massive spillage of empyema material.

6. Respondent failed to keep an adequate record for Patient A, including, but not limited to, failing to record a coherent post-anesthesia note.

B. On or about November 25, 1989 Respondent administered anesthesia to Patient B, an obese 39 year old female with a history of hypertension, during an elective tubal ligation, at Queens Hospital Center, 82-68 164th Street, Jamaica, New York. Patient B went into cardiac arrest in the post-anesthesia care unit. Patient B died on November 26, 1989 in the surgical intensive care unit.

1. Respondent prematurely extubated Patient B.

2. Respondent failed to adequately ventilate Patient B following the surgical procedure.

3. Respondent inappropriately failed to immediately reintubate Patient B when she was noted to be unresponsive upon arrival in the post-anesthesia care unit.

4. Respondent inappropriately failed to sedate Patient B and administer a dose of muscle relaxant sufficient to paralyze her, following two incidents of Patient B extubating herself.

5. Respondent inappropriately administered the narcotic antagonist Narcan to Patient B.

6. Respondent failed to keep an adequate record for Patient B, including, but not limited to, failing to record Patient B's vital signs and oxygen saturations during the initial post-extubation period, and failing to record a coherent post-anesthesia note.

FIRST THROUGH SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law section 6530(4) (McKinney Supp. 1994), in that Petitioner charges:

1. The facts in Paragraphs A and A1-6.
2. The facts in Paragraphs B and B1-6.

THIRD THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1994), in that Petitioner charges:

3. The facts in Paragraphs A and A1-6.
4. The facts in Paragraphs B and B1-6.

FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1994), in that Petitioner charges that Respondent committed at least two of the following:

5. The facts in Paragraphs A and A1, A2, A3, A4, A5 and/or A6, and/or B and B1, B2, B3, B4, B5 and/or B6.

SIXTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1994), in that Petitioner charges that Respondent committed at least two of the following:

6. The facts in Paragraphs A and A1, A2, A3, A4, A5 and/or A6, and/or B and B1, B2, B3, B4, B5 and/or B6.

SEVENTH THROUGH EIGHTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994), in that she failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Petitioner specifically charges:

7. The facts in Paragraphs A and A-6.

8. The facts in Paragraphs B and B-6.

DATED: New York, New York
March 31, 1994

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct