SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION : THIRD DEPARTMENT

In the Matter of ARTHUR TORIAN,

Petitioner,

v

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT,

Respondent.

Case #: 89695

NOTICE OF ENTRY OF ORDER

PUBLIC

PLEASE TAKE NOTICE that the annexed is a true copy of an Order duly filed and entered in the office of the Clerk of the Supreme Court of the State of New York, Appellate Division, Third Department, on the 24th day of July, 2001.

Dated: New York, New York
July 27, 2001

Yours, etc.,

Eliot Spitzer
Attorney General of the State of New York
Attorney for State Respondent
By:
KRISTIN WHITE
Assistant Attorney General
120 Broadway - 24th Floor
New York, New York 10271
(212) 416-6381

To: Carolyn Shearer, Esq.
Bond, Schoeneck & King LLP
111 Washington Avenue
Albany, NY 12210-2211

State of New York
Supreme Court - Appellate Division
Third Judicial Department

Decided and Entered: July 24, 2001

Case # 89695

In the Matter of the ARTHUR TORIAN, Petitioner,

v

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT, Respondent.

DECISION AND ORDER ON MOTION

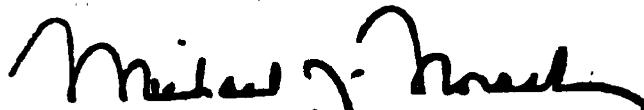
Motion for stay pending determination of review proceeding.

Upon the papers filed in support of the motion, and the papers filed in opposition thereto, it is

ORDERED that the motion is denied, without costs.

SPAIN, J.P., CARPINELLO, MUGGLIN, ROSE and LAHTINEN, JJ., concur.

ENTER:



Michael J. Novack
Clerk of the Court

TOTAL P.04

STATE OF NEW YORK SUPREME COURT | APPELLATE DIVISION THIRD DEPARTMENT

PUBLIC

In the Matter of the Application of

ARTUR TORIAN, M.D.

Petitioner,

- against -

THE STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT, a board under the auspices of the New York State Department of Health,

Respondent,

For a Judgment pursuant to CPLR Article 78.

ORDER TO SHOW CAUSE

Docket No.

RECEIVED

JUN 0 6 2001

NYS DEPT. OF HEALTH
DIVISION OF LEGAL AFFAIRS

Upon the annexed Petition of Artur Torian, M.D., verified on the 4th day of June, 2001, the annexed affirmation of Carolyn Shearer, Esq., affirmed on the 4th day of June, 2001, Administrative Review Board Determination and Order No. 01-6 dated May 31, 2001, State Board for Professional Medical Conduct Determination and Order No. SBMC 01-6 dated January 10, 2001, and upon all of the papers and proceedings previously had herein.

Let Respondent or its attorneys show cause before the Supreme Court, Appellate Division, Third Department, Justice Building, Albany, New York on the 25TH day of JUNE, 2001 at 9:30 o'clock in the forenoon of that day, or as soon thereafter as counsel can be heard, why a Judgment and Order should not be entered pursuant to Article 78 of the CPLR and Section 230-c(5) of the Public Health Law:

(a) staying Administrative Review Board Determination and Order No. 01-6 pending the hearing and resolution of this Article 78 proceeding;

(b) staying Respondent and its officers, agents, employees and representatives from enforcing or disclosing Administrative Review Board Determination and Order No. 01-6 pending the hearing and determination of this proceeding;

(c) annulling Administrative Review Board Determination and Order No. 01-6;

(d) granting such other and further relief which the Court deems just and proper, together with the costs and disbursements of this proceeding, on the ground that said Determination and Order is arbitrary and capricious, erroneous as a matter of law, and unsupportable by substantial evidence; and it is further

ORDERED, that Administrative Review Board Determination and Order No. 01-6 is hereby stayed pending the determination of the within motion for a stay; and it is further

ORDERED, that the motion brought on by this Order to Show Cause shall not be orally argued unless counsel are notified to the contrary by the Clerk of the Court.

Sufficient cause appearing therefore, service by personal service or by overnight mail upon the Respondent by serving the Division of Legal Affairs, Department of Health, Corning Tower, Albany, New York 12237, and upon Eliot Spitzer, Attorney General of the State of New York, Litigation Bureau, 120 Broadway 24th Floor, New York, New York 12041, of this order and the papers annexed hereto on the 6TH day of JUNE, 2001 shall be deemed sufficient; and it is further

~~ORDERED, that copies of any additional papers in support of the Petition shall be served personally or by fax on the Respondent, at the addresses set forth herein, on or before the ____ day of ______, 2001; and it is further~~

~~ORDERED, that copies of all responsive papers to be relied upon by the Respondent shall be served personally or by fax on or before the _____ day of ________, 2001, by delivery to Bond, Schoeneck & King, LLP, 111 Washington Avenue, Albany, New York 12210-2211, fax number (518) 462-7441.~~

DATED: June 5TH, 2001
Troy, New York

Honorable Edward O. Spain
Justice of the Supreme Court
Appellate Division, Third Department

ENTER:

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 31, 2001

PUBLIC

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee A. Davis, Esq.
NYS Department of Health
Corning Tower-ESP-Room 2509
Albany, New York 12237

Artur Torian, M.D.
821 Second Avenue
Troy, New York 12182

Artur Torian, M.D.
180 Lenox Avenue
Albany, New York 12208

Carolyn Shearer, Esq.
Hinman, Straub, Pigors &
Manning, P.C.
121 State Street
Albany, New York 12207-1622

RE: In the Matter of Artur Torian, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-6) 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.

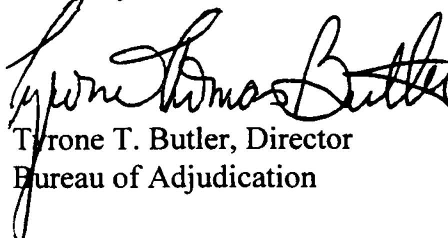
Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified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

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

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, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

In the Matter of	
Artur Torian, M.D. (Respondent)	**Administrative Review Board (ARB)**
A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	**Determination and Order No. 01- 6** COPY

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge Jeffrey Armon drafted the Determination

For the Department of Health (Petitioner):	**Lee A. Davis, Esq.**
For the Respondent:	**Carolyn Shearer, Esq.**

In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 2000), each party asks the ARB to nullify or modify a Determination by a BPMC Committee that the Respondent practiced medicine with negligence on more than one occasion and failed to maintain adequate medical records for two patients while acting as Medical Director at the Albany County Correctional Facility (hereinafter "ACCF"). The Committee determined to dismiss additional charges that Respondent practiced medicine with gross negligence, gross incompetence or with incompetence on more than one occasion. The Petitioner requests that the ARB modify the Determination by reversing the dismissal of those charges and, in addition, by increasing the penalty from the six month stayed suspension of Respondent's license and one year period of probation imposed by the Committee. Respondent's cross-appeal of the Committee's Determination contends that the finding of practicing the profession with negligence on more than one occasion should be overturned and that mitigating factors presented in the hearing record justify imposition of no penalty as to the charge of failing to maintain accurate records.

After reviewing the record and submissions by both parties, we overturn the Committee's Determination to not sustain the charges of practicing the profession with gross negligence on a particular occasion and with incompetence on more than one occasion and we sustain the dismissal of the charge of practicing the profession with gross incompetence on a particular occasion. The ARB unanimously determines to modify the penalty imposed by the Committee and suspends Respondent's New York medical license for a one year period, places Respondent on a three year period of probation thereafter during which he may only practice medicine when monitored by an approved licensed physician, restricts him from the practice of medicine in a correctional facility heath care system and imposes a civil penalty of $10,000 (Ten Thousand Dollars).

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(3-6) and (32) (McKinney Supp. 2000), by:

- practicing medicine with negligence on more than one occasion;
- practicing medicine with gross negligence;
- practicing medicine with incompetence on more than one occasion;
- practicing medicine with gross incompetence; and,
- failing to maintain accurate records.

These charges related to the medical care provided to Patients A and B during the period of 1997-8 at the ACCF, while Respondent served as Medical Director at that facility. A hearing on those charges ensued before the BPMC Committee, which subsequently rendered the Determination now on review.

The Committee determined that Respondent failed to meet accepted standards of medical practice in his treatment of Patient A, a Type I diabetic. The patient had a history of diabetes since childhood and presented to the correctional facility with regular insulin. Notwithstanding these facts, Respondent ordered all insulin withheld for a two week period because he claimed he was uncertain the patient was truly a Type I diabetic. Thereafter, Respondent prescribed NPH insulin, instead of regular insulin, allegedly because he believed the patient was noncompliant with his diet. As a result, Patient A experienced multiple episodes of hypoglycemia and high blood glucose levels.

The patient subsequently complained of severe stomach pain and cramping, diarrhea and weight loss, symptoms consistent with appendicitis. Respondent failed to perform or order the performance of a history and physical examination, as would have been appropriate, and failed to order laboratory tests. Respondent was repeatedly informed of the patient's deteriorating condition, yet failed to provide treatment because he believed the patient to be faking his symptoms. Ultimately, other ACCF staff ordered the patient's transfer to a hospital where he was found to have a ruptured appendix. The Committee concluded that Respondent's care and treatment of the patient's diabetes and developing appendicitis demonstrated negligence in the practice of medicine on more than one occasion, but was not so egregious as to constitute gross negligence. The Committee also determined that Respondent's conduct in his treatment of Patient A did not demonstrate incompetence on more than one occasion or gross incompetence, but did sustain a charge that he failed to maintain an accurate record for the patient.

Patient B saw Respondent with complaints of headaches, knee pain, slurred speech and difficulty in concentration. Respondent failed to conduct or order any appropriate tests, including a neurological examination, to determine a cause of the complaints and assumed they were caused by medications that the patient was taking. It was subsequently determined that Patient B was terminally ill. The Committee again concluded that Respondent's care and treatment of the

patient demonstrated negligence in the practice of medicine on more than one occasion, but was not so egregious as to constitute gross negligence. The Committee also determined that Respondent's conduct in his treatment of Patient B did not demonstrate incompetence on more than one occasion or gross incompetence, but did sustain a charge that he failed to maintain an accurate record for the patient.

In reaching their findings and conclusions the Committee evaluated the credibility of the witnesses. The Committee considered the Department's expert to be knowledgeable and objective, and accorded great weight to his testimony. The surgeon who operated on Patient A and two staff persons of the ACCF were each considered to be credible. Conversely, the testimony of two physicians and three fact witnesses who appeared on behalf of the Respondent was given little weight or was discounted by the Committee. The Respondent was seen by the Committee as being evasive and unwilling to assume responsibility for his actions.

Review History and Issues

The Committee rendered their Determination on January 10, 2001. This proceeding commenced on January 18, 2001, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's and Respondent's briefs and their reply briefs. The record closed when the ARB received the Respondent's reply brief on February 28, 2001.

The Petitioner alleges that the Committee erred in its Determination by:

- failing to find that Respondent was incompetent on more than one occasion; and
- failing to find that Respondent had practiced medicine with gross negligence; and
- failing to impose on Respondent a significant and actual suspension of his license.

Respondent raised the following issues in his brief:

- the Committee failed to fully appreciate circumstances at the facility and Respondent's role there; and
- the Committee made insupportable determinations as to the weight of the testimony of the witnesses; and
- Respondent was not negligent in his care of the two patients.

Determination

All ARB members participated in this case, considered the record and the parties' briefs. We sustain the Committee's findings and judgement on credibility, overturn the Committee's Determination to not sustain the charges of practicing the profession with gross negligence on a particular occasion and with incompetence on more than one occasion and sustain the dismissal of the charge of practicing the profession with gross incompetence on a particular occasion. The ARB unanimously determines to modify the penalty imposed by the Committee as is discussed, below.

Witness credibility: The Committee clearly explained why greater weight was accorded to the testimony of Petitioner's witnesses. Their answers were considered to be direct and objective and fact witnesses were considered to have an independent recollection of the relevant events. The Committee felt that the testimony offered by two physicians on behalf of the Respondent was in response to narrowly posed questions not intended to elicit their general opinions of Respondent's treatment. Other testimony from fact witnesses at the facility were viewed as unsupported by the record or biased in favor of Respondent. His own testimony was seen by the Committee as self-serving and evasive. The ARB considers that the Committee's credibility determinations and the weight accorded to the testimony of each witness should be deferred to and we see no cause to alter such findings.

Gross negligence and incompetence on more than one occasion: The Committee determined that Respondent's treatment of Patient A's diabetes demonstrated both negligence and incompetence. It found that the patient was placed at risk by having all insulin therapy withheld for a two week period. It was also found that Respondent received the patient's medical records which verified that Patient A was a Type I diabetic who was on a regimen of regular insulin and that thereafter Respondent knowingly prescribed NPH insulin instead. The ARB considers these actions to be inhumane treatment of the patient and such egregious deviations from accepted standards of practice as to constitute gross negligence.

Respondent also ignored obvious complaints of the patient which were consistent with a diagnosis of appendicitis. Notwithstanding the continuous complaints, Respondent made no effort to determine their cause and instead chose to disbelieve Patient A. The ARB feels this not only demonstrated negligence, but also gross negligence and incompetence in the practice of medicine. It did not appear that Respondent possessed the skill or knowledge to treat symptoms of either diabetes or appendicitis. The determination to not sustain charges of gross negligence and incompetence on more than one occasion is consequently reversed.

Penalty: The Committee considered the difficult working conditions at the ACCF in mitigation when imposing its penalty. Also considered was the fact that Respondent was no longer employed at the facility and that there was no allegation of misconduct related to his treatment of patients in his private practice. The ARB considers these factors to be substantially out-weighed by the Respondent's egregious deviations from accepted medical standards in his treatment of these two patients. As the Committee itself noted, "Having recognized the problems at the correctional facility, the Hearing Committee nevertheless strongly believes that Respondent, having undertaken the role of medical director, had the obligation to render the appropriate standard of care to the inmates" (Committee Determination, at pages 29-30). We believe the penalty imposed by the Committee to be wholly inadequate based on the record and conclude that it should be significantly modified.

The fact that Respondent was employed under difficult conditions was considered as a mitigating factor only so far as to cause us to not determine that his medical license should be

revoked. Having found his actions to not be acceptable and having determined to discount or consider not credible all testimony presented on his behalf, there could be no reason for the Committee to not impose a meaningful penalty. His failure to appropriately treat Patient A, under the guise of a belief of inherent manipulation by an inmate, could only be seen as inhumane. The status of the patients as prisoners did not deprive them of their entitlement to adequate medical care and the penalty imposed should be substantial when the deviation from accepted medical standards is so great.

The ARB unanimously determines to modify the penalty imposed by the Committee and suspends Respondent's New York medical license for a one year period, places Respondent on a three year period of probation thereafter during which he may only practice medicine when monitored by an approved licensed physician, restricts him from the practice of medicine in a correctional facility heath care system and imposes a civil penalty of $10,000 (Ten Thousand Dollars).

<u>**ORDER**</u>

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB **<u>OVERTURNS</u>** the Committee's Determination to not sustain the charges of practicing the profession with gross negligence on a particular occasion and with incompetence on more than one occasion.

2. The ARB **<u>SUSTAINS</u>** the Committee's Determination to dismiss the charge of practicing the profession with gross incompetence on a particular occasion.

3. The ARB **<u>SUSPENDS</u>** Respondent's New York medical license for a one year period and places Respondent on a three year period of **<u>PROBATION</u>** thereafter, during which he shall comply with the Terms of Probation, attached hereto as Appendix I.

4. The ARB imposes a **<u>CIVIL PENALTY</u>** of **<u>TEN THOUSAND DOLLARS</u>** **<u>($10,000)</u>** upon Respondent, such penalty to be payable in full within sixty (60) days of the effective date of this Order. Payment shall be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1258
Albany, New York 12237.

Robert M. Briber

Thea Graves Pellman

Winston S. Price, M.D.

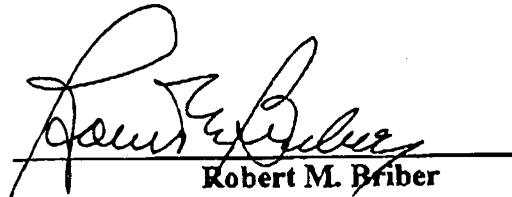
Stanley L. Grossman, M.D.

Therese G. Lynch, M.D.

In the Matter of Artur Torian, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Torian.

Dated: May 2, 2001

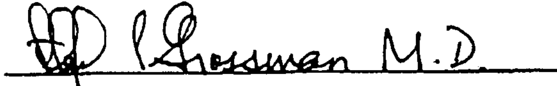


Robert M. Briber

In the Matter of Artur Torian, M.D.

Stanley L. Grossman, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Torian.

Dated: April 27, **2001**

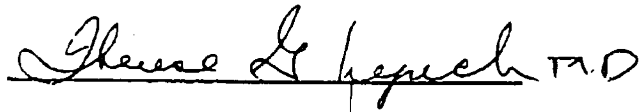


Stanley L Grossman, M.D.

In the Matter of Artur Torian, M.D.

Therese G. Lynch, M.D., an ARB Member, concurs in the Determination and Order in the Matter of Dr. Torian.

Dated: May 2, 2001

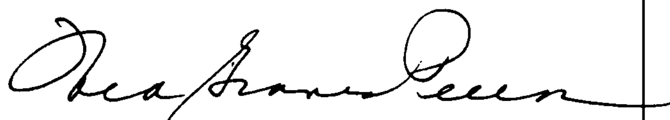


Therese G. Lynch, M.D.

In the Matter of Artur Torian, M.D.

Thea Graves Pellman, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Torian.

Dated: 5/21, **2001**



Thea Graves Pellman

APPENDIX I

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession. Respondent acknowledges that if he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall practice medicine only when monitored by a licensed physician, board certified in Family Medicine ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

8. Respondent's practice of medicine is restricted to prohibit further medical practice in a correctional facility.

9. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

January 11, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee A. Davis, Esq.
NYS Department of Health
Corning Tower-ESP-Room 2509
Albany, New York 12237

J. ARTHUR ~~Artur~~ Torian, M.D.
821 Second Avenue
Troy, New York 12182

J. ARTHUR ~~Artur~~ Torian, M.D.
180 Lenox Avenue
Albany, New York 12208

Carolyn Shearer, Esq.
Hinman, Straub, Pigors &
Manning, P.C.
121 State Street
Albany, New York 12207-1622

RE: In the Matter of J. ARTHUR ~~Artur~~ Torian, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-6) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

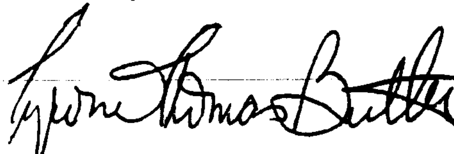
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER OF J. ARTHUR ~~ARTUR~~ TORIAN, M.D.	DETERMINATION AND ORDER

BPMC #01-6

A Notice of Hearing and Statement of Charges, both dated May 19, 2000, were served upon the Respondent, Artur Torian, M.D. **DONALD CHERR, M.D. (CHAIR), HRUSIKESH PARIDA, M.D., AND JOHN O. RAYMOND**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Esq., Assistant Counsel. The Respondent appeared by Hinman, Straub, Pigors & Manning, P.C., Carolyn Shearer, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CASE

Petitioner has charged Respondent with five specifications of professional misconduct. The charges relate to Respondent's medical care and treatment of two patients at the Albany County Correctional Facility. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and failing to maintain records which accurately reflect the evaluation and treatment of the patients. Respondent denied the allegations.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. 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 the cited evidence.

1. ~~Artur~~ J. ARTHUR Torian, III, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the

New York State Education Department's issuance of license number 105059 on October 16, 1969. (Pet. Exh. #2).

2. Respondent's name was legally changed from James Arthur Torian to Artur Torian by Court Order. (Exh. C).

3. Respondent was the Medical Director at the Albany County Correctional Facility (hereinafter "ACCF") during all times relevant to this proceeding. As Medical Director, Respondent was "...responsible for the provision of health care services to all detainees [at the ACCF] and for making the final medical judgements regarding the care provided to inmates within the facility, as well as providing primary care." (T. 26-27; Exh. 19).

Patient A

4. Patient A, a 26 year old male, reported to the ACCF on July 14, 1997. He presented as an insulin dependent diabetic since 12 years of age. He reported complications resulting in laser surgery on his eyes and a right great toe amputation due to osteomyelitis. He also reported having received treatment for diabetes from Dr. Yaconno, an endocrinologist. (Ex. 4, pp. 3, 36-37).

5. Respondent provided medical care and treatment to Patient A during the period including July 14, 1997 through November 6, 1997, at the ACCF, Albany, New York. (Ex. 4).

6. Diabetes is a disease affecting the metabolism of the body. It is characterized by the body's inability or difficulty in utilizing glucose, potentially affecting every organ system in the body. (T. 183).

7. Clinical problems often present in those with diabetes include retinal disease, cardiac disease, renal disease, peripheral vascular disease, neuropathies, and metabolic problems. (T. 193).

8. There are two basic types of diabetes mellitus. They are generally classified as Type I and Type II. In a Type I diabetic, there is a virtual absence of insulin secretion from the pancreas. In a Type II diabetic, the pancreas secretes insulin, but the body is resistant to the effect of the insulin. (T. 183-184).

9. There are a variety of treatments for diabetes, including insulin therapy (in various forms), oral hypoglycemic agents, diet, exercise and other non-medicinal regimens. (T. 185).

10. A Type I diabetic has an absolute need for insulin. Removing insulin therapy from a Type I diabetic can lead to a condition called ketoacidosis. (T. 200, 528-529, 549).

11. Ketoacidosis is a severe metabolic derangement that impacts every organ system in the body, with potentially severe consequences including dehydration, brain dysfunction, cardiac dysfunction and death. Ketoacidosis can occur within a period of several hours to no more than a few days. (T. 200-201).

12. The risk of ketoacidosis is increased when the patient experiences high glucose levels. Stress can also be a contributing factor to ketoacidosis. (T. 549, 554).

13. Patient A presented to the ACCF on July 14, 1997 as a Type I diabetic, and surrendered a quantity of regular insulin to the ACCF staff. (T. 191, 208-209, 269; Exh. 4, pp. 3, 36, 112; Exh. 6, p. 3).

14. Normal fasting sugar levels range from 60-126. Normal sugar levels two hours after eating a meal should be less than 160. (T. 198).

15. Between July 14, 1997 and July 31, 1997, the blood sugar levels of Patient A were measured on a regular basis. They fell below 200 on only two occasions: the presenting level of 134 on July 14, 1997 and the following day with a blood sugar of 174. The remainder of the sugars recorded from July 16, 1997 through July 31, 1997 all exceeded 200: on five occasions, the blood sugar levels exceeded 300

and on four occasions, the blood sugar levels exceeded 400. (Exh. 4, p. 113).

16. On July 25, 1997, at 07:45 hours, Patient A reported to an examining nurse that he was feeling "very sick from elevated sugar." The blood sugar level was recorded as 254 at that time. Patient A also informed the examining nurse that sugars in the 200 range were high for him. The note indicates Respondent was aware of the blood sugar levels for Patient A. (Exh. 4, p. 37).

17. The blood sugar levels recorded for Patient A between July 14, 1997 through July 31, 1997 are elevated to such a degree as to be medically significant. (T. 201-202).

18. In a letter written by Patient A that was date stamped as received on August 4, 1997, Patient A complained that he had not received any insulin since his entry into the ACCF on July 14, 1997, and that he was not feeling well, complaining of weakness of body, blurred vision, pain in the kidneys, and blood in the stool. (Exh. 4, pp. 57-58).

19. Weakness and blurry vision can be signs of excessively high blood sugar. (T. 566).

20. The blood sugar levels exhibited by Patient A between July 14 through July 31, 1997 caused significant short

term harm to the patient, including excessive dehydration and problems with his vision. (T. 202-204).

21. Respondent was aware of the persistently elevated blood sugars of Patient A between July 14 and July 31, 1997. (Exh. 4, pp. 37-39).

22. By failing to provide any insulin to Patient A between July 14 and July 31, 1997, Respondent failed to meet the minimum standards expected of a treating physician. By removing all insulin therapy from the patient, Respondent placed Patient A at risk. (T. 208-209).

23. Regular insulin acts sooner than NPH insulin and has a shorter effective duration than NPH. (T. 185-187).

24. On July 29, 1997, the ACCF received Patient A's prior medical records from the Community Health Plan (CHP). The CHP records indicated that Patient A was a Type I diabetic with advanced complications. The records further verify that Patient A was on a regimen of regular insulin. (Exh. 4, pp. 161, 167, 179, 189).

25. At the time of his incarceration at the ACCF, Patient A was experiencing the advanced stages of diabetes. (T. 211-212, 632).

26. Despite this prior history and treatment, Patient A did not receive regular insulin as a course of therapy at

the ACCF until September 30, 1997. (T. 216; Exh. 4, pp. 6-30).

27. Patient A wrote five letters regarding his diabetic care at the ACCF that became part of his medical record. Three of the five letters were addressed specifically to Respondent. In these letters, Patient A complained that the lack of regular insulin and other care consistent with that provided by CHP was causing him discomfort and complications. (Exh. 4, pp. 57-59, 62-66).

28. Patient A was hospitalized at Albany Medical Center Hospital (AMCH) from August 8 through August 15, 1997. Upon his discharge, Patient A received an order for regular insulin (humulin). (T. 214, Exh. 4, pp. 75-94, 82).

29. Instead of prescribing regular insulin, Respondent ordered NPH insulin for Patient A. (Exh. 4).

30. On September 9, 1997, Patient A was sent to AMCH Emergency Department because he was suffering from hypoglycemia. (Exh. 4, p. 49).

31. Samer El Deiry, M.D., an endocrinologist, saw Patient A in consultation on September 10, 1997. Dr. El Deiry recommended that Patient A discontinue NPH insulin and begin a regimen of sliding scale regular insulin, due to hypoglycemia and renal deficiencies. Dr. El Deiry also

recommended use of an oral medication (Glipizide) and that the patient return for follow-up in one week. (Exh. 6, p. 4).

32. The recommendation to discontinue the NPH insulin and begin regular insulin is medically sound. By prescribing a quicker and shorter acting insulin, episodes of hypoglycemia are more likely to be avoided. (T. 226-227).

33. Patient A complained in his letters to the Medical Department at ACCF that the administration of NPH insulin caused hypoglycemic episodes during the evening. (Exh. 4, pp. 57-59, 62-66).

34. Dr. El Deiry's recommendation regarding regular insulin and Glipizide was not followed from September 11, 1997 through September 29, 1997. (Exh. 4, pp. 21-30).

35. The only rationale provided by Respondent for not abiding by the recommendation of the endocrinologist is a concern that regular insulin will cause significant drops in blood sugar. (Exh. 4, p. 52).

36. This rationale is not medically justified. (T. 230-231).

37. On September 10, 1997, Respondent ordered a 1500 calorie diet for Patient A. He did not order an American Diabetes Association (ADA) diabetic diet for the patient. (T. 218; Exh. 4, pp. 21, 35).

38. Diabetic diets were not available at the ACCF. The only special diets available (through the nearby Albany County Nursing Home) were sodium-restricted diets and diets for patients on dialysis. (T. 388, 395).

39. Respondent's failure to follow the recommendation of Dr. El Deiry failed to meet minimum medical standards. (T. 232-234).

40. Respondent's failure to prescribe regular insulin for Patient A prior to September 30, 1997, his failure to respond to the concerns expressed by Patient A, and his failure to develop a comprehensive response to the complaints and physical findings of Patient A with regard to his diabetes fell below the minimum standards of medical care. (T. 220-224).

41. Record keeping by the physician is critical in the treatment of a patient. The medical record is the key repository of all information about the patient. The attending physician is required to articulate reasons for treatment (or decisions not to treat) in a rational form. The medical record is also a method of refreshing the care giver's own memory about what has previously transpired during the course of treatment. (T. 235-236).

42. On August 2, 1997, Patient A complained of severe stomach pain, with blood in his stools for three to four days, and diarrhea. The medical record indicates that as of August 2, 1997, Patient A had lost ten pounds since the time of his incarceration on July 14, 1997. These complaints were made to Ms. Brenda Enfield. She conveyed this information to Respondent by telephone, who ordered the inmate to C Building for bed rest. Respondent did not order any blood tests or any other diagnostic tests in response to the symptoms reported on August 2nd. (T. 459-462; Exh. 4, p. 40).

43. On August 4th, Patient A was walking from his housing location to the infirmary. He was unable to make it up the stairway to the infirmary, and was observed lying on the stairs. Patient A stated, "I'm tired, I need insulin." Patient A was seen by Ms. Patricia McCully, an LPN at the ACCF. Loss of energy and weight loss are consistent with an acute abdominal injury such as a ruptured appendix. (T. 242-243; Exh. 4, pp. 40-41).

44. Respondent wrote an entry in Patient A's medical record, dated August 4, 1997, that Patient A "was trying to pretend that he is in shock or coma," and the entry notes further that the patient "'passed out' on steps." Respondent also noted that patient "is 'fakeing' [sic] lethergy [sic]."

Respondent wrote in the medical chart that "obviously pt is mentally disturbed." (Exh. 4, p. 41).

45. Despite the observations of weakness as reported to Respondent, he failed to order any laboratory or diagnostic tests for Patient A. (Exh. 4).

46. On August 5, 1997, Patient A was documented to have lost 12½ pounds since his incarceration. Respondent was advised of this fact. (Exh. 4, p. 41).

47. Respondent saw Patient A in the medical department on August 6, 1997. He noted that the patient was "markedly unkept" and in ketosis. (Exh. 4, p. 41).

48. In an entry made on August 6, 1997, Patient A was reported to have not eaten in three days. The patient later admitted to eating pudding, tomato soup and Kool-Aid during that period of time. There is no indication in the record as to the quantity of food consumed. (Exh. 4, p. 42).

49. On August 8, 1997, at 1:00 p.m., Patient A was observed by Nurse Voland to be lying on his abdomen. Patient A reported to the nurse that "my belly hurts and I need to go to the hospital." (Exh. 4, p. 42).

50. Ms. Voland noticed that the patient's skin was clammy, and that the cell contained underwear covered with

fecal material and a toilet bowl full of un-flushed diarrhea. (Exh. 4, p. 42).

51. Ms. Voland called Respondent regarding these findings. Respondent was hesitant about sending the patient to the hospital. He ordered Patient A to clean himself and his cell. (T. 147-148; Exh. 4, pp. 11, 42).

52. Respondent ordered laboratory studies to evaluate the patient's BUN and creatinine levels. (Exh. 4, p. 42).

53. At a minimum, a complete blood count instead of general chemistries should have been ordered for Patient A given the complaints reported between August 2 and August 5, 1997 to rule out potential differential diagnoses based upon the recorded complaints. (T. 242, 248-249).

54. Respondent's failure to order the necessary blood work for Patient A given the symptoms presented on August 2 through August 5, 1997 fell below the minimum standards of medical care. (T. 248-249).

55. Common symptoms of appendicitis are abdominal pain, nausea, diarrhea, vomiting, fever, and assuming body positions consistent with pain, such as being slumped over or in a position where one's legs are drawn up to the chest. (T. 237).

56. Severe abdominal cramping and pain in a patient requires the physician to consider multiple differential diagnoses. (T. 596).

57. A sudden loss of blood pressure is consistent with major dehydration. The drop in blood pressure exhibited by Patient A commencing on August 4, 1997 was potentially significant. (T. 600-601; Exh. 4, p. 120).

58. Failure to diagnose and promptly treat appendicitis can result in a perforation of the appendix and a spillage of pus and intestinal contents throughout the abdomen. (T. 237-238).

59. The spillage of pus and intestinal contents can lead to an abdominal infection which can be spread through the bloodstream to the rest of the body. If the condition is permitted to continue it can result in death due to sepsis. (T. 238).

60. A prudent physician who has been presented with an individual with complaints of severe stomach cramping and pain, and blood in the stool would take a direct history from the patient and perform a physical examination. At a minimum, the examination would include examination of the abdomen and performing a rectal examination. (T. 239).

61. The physical examination should include examination for muscular rigidity, rebound tenderness, and checking for a Robsing sign, or Orburator sign. (T. 596-597).

62. Patient A's medical record contains no evidence that any of the tests and physical examinations described above were performed on Patient A following the complaints presented on August 2, 1997. There is nothing to indicate that Respondent ordered such examinations or tests to be performed. (T. 596-598).

63. Diarrhea can be a sign of appendicitis. Although a fever is often associated with appendicitis, the fever is often not elevated. (T. 598).

64. Following the temperature recorded on August 2, 1997 at 1:40 p.m., as reflected in Patient A's medical record, there is no evidence that Respondent documented Patient A's temperature following the complaints exhibited on August 2, 1997. (Exh. 4, p. 40).

65. While the medical record of Patient A does not contain any evidence of right lower quadrant pain, which is often associated with appendicitis, there is nothing to indicate that Respondent either performed or ordered such examination to rule out right lower quadrant pain. (T. 601; Exh. 4, pp. 40-42).

66. Respondent did not document in Patient A's medical record that a history was elicited or ordered to be elicited from the patient to determine where the reported pain started or where it was at the time that Patient A was seen by medical personnel. (T. 601; Exh. 4, pp. 40-42).

67. On August 8, 1997, Patient A was unable to come to the infirmary for his insulin injection, and Ms. Voland went to his cell for to administer the injection. When she arrived, he informed her that he was to sick to come to the medical department. Ms. Voland observed that the patient was lying on his abdomen on his cot. His clothing was strewn around the cell and contained fecal material. His toilet and toilet seat contained fecal material. (T. 143; Exh. 4, p. 42).

68. At 07:20 hours on August 8, 1997, Patient A complained of kidney and abdominal pain. Ms. Voland observed that Patient A's skin was clammy, that he was diaphoretic, and was unable to sit up or move around. (T. 144; Exh. 4, p. 42).

69. Ms. Voland returned to the medical department and telephoned Respondent at his private office. She informed Respondent regarding Patient A's condition, and indicated that in her opinion, the patient should be transferred to an emergency room for evaluation. Respondent indicated that

prior to sending out Patient A, he should be ordered to clean up his cell and himself, and that his symptoms and conditions be monitored and reported back to Respondent. (T. 146-148; Exh. 4, pp. 11, 42).

70. Ms. Voland reported Patient A's condition to Holly Collett, the health administrator of the ACCF. Ms. Voland reported her concern for the health and safety of Patient A. Ms. Collett then spoke with Respondent by telephone regarding Patient A. (T. 69-70, 148-149).

71. Ms. Collett did not speak with the physician assistant at the ACCF as he was not in the building at the time. Upon informing Respondent of the condition of Patient A, Respondent informed Ms. Collett that she should mind her own business. (T. 71-72).

72. Staff in the vicinity of Patient A's cell indicated to Ms. Collett that he was not able to get out of bed to clean himself or his cell. After speaking with the superintendent of ACCF, Ms. Collett again spoke with Respondent. He informed Ms. Collett that Patient A should clean the feces off himself. He also indicated that he would make a determination about the patient after receiving the laboratory results that he had requested. (T. 72-73, 149).

73. On August 8, 1997, Patient A was transferred to AMCH. He was treated at AMCH by Edward C. Lee, M.D. When Patient A presented to the AMCH emergency department, he was suffering from multiple organ failure. (T. 304, 312; Exh. 4, pp. 11-12, 42; Exh. 5, pp. 5, 7-8).

74. Dr. Lee had an independent recollection of treating Patient A on August 8, 1997, even though his testimony occurred nearly three years after the date of treatment, and after approximately 2000 surgical procedures since the date of treating Patient A. Dr. Lee remembered Patient A because it was unusual for an individual to present as badly as Patient A presented for appendicitis. Dr. Lee remembered Patient A as being a very sick person. (T. 313).

75. Patient A was in intense distress and breathing quite rapidly when examined by Dr. Lee. The patient had an acute, "quite rigid" abdomen. (T. 305).

76. X-rays of Patient A revealed pneumoperitoneum indicating a perforated portion of the gastrointestinal tract. Patient A required emergency surgery. (T. 305; Exh. 5, pp.7-8, 70).

77. Laboratory studies performed at AMCH on August 8th indicated that Patient A was experiencing moderate kidney failure. His creatinine level was elevated at 3.1, which is

consistent with dehydration or infection. The elevated creatinine level indicated that the patient had been sick for a period of time. (T. 307, Exh. 5, p. 169).

78. Dr. Lee's pre-operative opinion on Patient A's condition was that there was a sever infection, most likely related to the acute abdomen and a likely case of bacterial peritonitis. (T. 307).

79. Dr. Lee performed surgery on Patient A. During the course of surgery, he discovered a "copious" amount of purulent material - approximately one liter in quantity. The consistency of the purulent material was very thick and fibrous. This is consistent with a perforation that has existed for a period of several days. (T. 310-311; Exh. 5, pp. 70-71).

80. At the time Patient A presented to the AMCH emergency department on August 8, 1997, his appendix had been ruptured for a period of several days. (T. 312).

81. Patient A's appendix was likely inflamed on August 1 or 2, 1997, and likely perforated shortly thereafter. (T. 248).

82. Respondent's failure to perform a physical examination and/or order the performance of a physical examination, given the symptoms presented by Patient A between

August 2, 1997 and August 8, 1997, failed to meet the minimum standards of medical practice. (T. 250-251).

Patient B

83. Respondent provided medical care to Patient B, a 43 year old female, during the period including July 8, 1998 through July 15, 1998, at the ACCF, Albany, New York. (Exh. 7).

84. Respondent's treatment of Patient B included pain management for headaches, knee pain, general medical complaints, as well as complaints of slurred speech and difficulty in concentration. (Exh. 7, pp. 23-27).

85. Throughout the course of her treatment at the ACCF, Patient B complained of headaches. (Exh. 7, pp. 21-27).

86. On June 30, 1998, Patient B's complaints changed significantly, when it was reported that she had experienced episodes of slurred speech, difficulty remembering words, and an unusual "feeling". (Exh.7, p. 24).

87. Respondent saw Patient B on July 8, 1998 for "multiple complaints." There is nothing in Respondent's entry for July 8, 1998 to indicate whether a history or a physical examination was conducted at that time. (Exh. 7, p. 24).

88. Respondent next encountered Patient B on July 15, 1998 regarding "migraine" headaches. Respondent noted in his

entry of July 15, 1998 that Patient B exhibited slurred speech, an inability to concentrate, and trouble moving. There is nothing in the entry for July 15, 1998 to indicate that a physical or neurological examination was ordered or performed. (Exh. 7).

89. A variety of conditions can cause slurred speech and difficulty remembering words. Some of these conditions can indicate significant central nervous system disease, including brain tumor, stroke, and central nervous system infection. It is incumbent upon the examining physician to locate the cause of the slurred speech and memory problems. (T. 323).

90. A physician who is presented with the symptoms of slurred speech, difficulty remembering words and an inability to concentrate should elicit a detailed history from the patient and perform a physical examination, including a neurological examination. The examination should include an assessment of the weakness of musculature on one side of the body or the other, visual field defects, mental status examination, and the presence or absence of motor sensory cognitive components. Further investigation, including imaging studies and laboratory studies should be conducted based upon the findings of the history and neurological

examination. Frequently, with central nervous system problems, there are other physical findings that can be detected by a physician, but not by the patient. (T. 325-326).

91. The failure of Respondent to perform a physical or neurological examination of Patient B following his contacts with the patient on July 8 and 15, 1998 is a deviation from the minimum standards of practice. (T. 328-329).

92. Patient B was eventually diagnosed at AMCH with terminal cancer of the lung, with metastasizes to the adrenal glands and the brain. (T. 745).

Circumstances at ACCF

93. A correctional facility medical unit is unlike a hospital, a physician's office, or an ambulatory care setting. The medical unit at ACCF was understaffed, and supplied with "bare minimum equipment." (T. 387, 419).

94. The 700 inmates at the correctional facility have access to the medical unit only through a sick slip system. Sick slips are triaged by a nurse, who assesses the legitimacy and severity of the complaint, and selects the patients who are to be seen by the physician's assistant (PA) or the physician. (T. 353-357).

95. During the time period at issue, patients' mental health records were isolated from their medical charts. Although the medical unit was responsible for dispensing medications ordered by the mental health staff, the medical unit staff had no access to mental health records. (T. 121, 348).

96. A patient referred to mental health by the medical unit staff would be triaged through psychiatric social workers and a psychologist before being seen by a psychiatrist, and a consultation report was not sent back to the medical unit. (T. 435).

97. Diabetic diets were not available. The only special diets available through the nearby Albany County Nursing Home were sodium-restricted diets, and diets for inmates on dialysis. (T. 388, 395).

98. Respondent, as a part-time employee of ACCF was only on-site a few mornings per week. Approximately two percent of the patients treated in the medical unit were seen personally by Respondent, as he saw only those patients who had been triaged through the sick slip system by the nurses and the PA. (T. 772, 790).

CONCLUSIONS OF LAW

Respondent is charged with five specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg, Esq., then General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the

purpose of which is sole to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. Petitioner presented the testimony of Richard B. Toll, M.D., and Edward C. Lee, M.D. Dr. Toll, who is board certified internal medicine, testified in a forthright, informed fashion regarding the medical care provided by Respondent to Patients A and B. When questions were posed to Dr. Toll that were favorable to Respondent, he similarly answered them directly, without equivocation. The Committee determined that Dr. Toll's testimony should be given great weight.

Dr. Lee is the surgeon who operated on Patient A following his admission at AMCH on August 8, 1997. Dr. Lee also testified in a direct and forthright manner. Significantly, Dr. Lee had an independent recollection of the events surrounding the treatment of Patient A, due to the patient's poor condition upon admission. The Hearing Committee found Dr. Lee to be a credible witness.

Petitioner also presented two fact witnesses. Holly Collett is the public health administrator at the ACCF. She gave direct answers to questions, and asked for clarification if she did not understand a question. No credible motive for fabrication of testimony was presented by Respondent. The Committee determined that Ms. Collett was a credible witness.

Petitioner also presented Mary Voland, a nurse at ACCF. Ms. Voland gave direct and matter-of-fact testimony, and indicated that she had a favorable relationship with Respondent. The Committee found her to be a credible witness.

Respondent presented the testimony of two physicians, three fact witnesses, and testified on his own behalf. Samer El Deiry, M.D. is board certified in internal medicine, and endocrinology. He was called in to evaluate Patient A's diabetes when the patient was hospitalized. Ronald Stram, M.D. is board certified in emergency medicine.

Both physicians are well qualified, and provided credible testimony. Nevertheless, the Committee had concerns regarding their testimony. In both instances, the questions posed by counsel for Respondent were very carefully crafted to elicit specific, pointed responses. Neither was asked to provide their medical opinions regarding Respondent's treatment of Patient A, the only patient whose care they reviewed. Accordingly, the Hearing Committee did not give great weight to their testimony.

Respondent also presented the testimony of Patricia McCully, an LPN who had worked at the ACCF. Her testimony, while favorable to Respondent, was not necessarily supported by the record. For example, Ms. McCully testified that she

examined Patient A on August 4, 1997 after being informed that he had difficulty walking up the stairs that lead to the medical unit. She testified that upon examination, Patient did not appear to be in distress. (T. 364-365). However, the medical record merely notes that the patient complained of being tired, and that his blood sugar was 314, a significantly elevated level. The entry contains no information to support Ms. McCully's claim that the patient was fine. (Ex. 4, p. 40). Such discrepancies led the Committee to discount Ms. McCully's testimony.

Similarly, the testimony presented by Margaret Courtier and Brenda Enfield was obviously slanted in favor of Respondent and against the patients, even without any support from the medical records. The Committee determined that their testimony should also be discounted.

Respondent also testified on his own behalf. It is obvious that Respondent has a stake in the outcome of this case. Nevertheless, the Hearing Committee found his testimony to be especially troubling. Respondent gave extremely evasive answers to questions, particularly on cross examination. Respondent testified that Patient A's drop in blood pressure from 140/80 on August 4, 1997 to 104/60 on August 6, 1997 was not significant (T. 687-688), despite testimony to the contrary from his own

expert, Dr. Stram (T. 601). Despite the fact that Respondent was medical director at the ACCF, he refused to acknowledge any responsibility for the welfare of the patients "I was not any, in fact medical director." (T. 667). "My job was to cosign for the physician assistant. That was my job .... So, basically, I gave them the few hours that I was there as a teacher more than anything else." (T. 768-769). Respondent's testimony significantly weakened his credibility with the Hearing Committee.

The Hearing Committee recognized that the conditions under which Respondent practiced at the ACCF were far from ideal. He was only on site for a few hours per day, several days per week. When he was there, he only saw those patients which had been triaged by the nurses through the "sick slip" system. He had to rely on the nurses to properly screen patients. He also had to rely on the nurses to call him and to convey an appropriate sense of urgency regarding any emergent situations.

Having recognized the problems at the correctional facility, the Hearing Committee nevertheless strongly believes that Respondent, having undertaken the role of medical director, had the obligation to render the appropriate standard of care to

the inmates. However, his treatment of the two patients at issue in this proceeding failed to meet that standard.

Patient A

Patient A presented to the ACCF on July 14, 1997 as a Type I diabetic. He had been diagnosed with diabetes as a child, and presented to the correctional facility with regular insulin, having last taken insulin that morning. Despite this history, Respondent ordered all insulin withheld from Patient A, so that he could observe how the patient adjusted to the prison environment. The results were predictable - within two days, Patient A's blood sugar level rose from the 139 recorded on July 14th to levels that routinely exceeded 200, and periodically exceeded 300 and 400. These are dangerously high blood sugar levels.

Respondent claimed that he was not certain whether Patient A was truly a Type I diabetic. By doing so, he ignored the simple facts contained in the patient's initial history and physical examination, as well as the fact that he had brought regular insulin with him to the prison. Respondent's attitudes toward Patient A, was distorted by the fact that he did not believe what the patient told him, or told the staff.

On July 29, 1997, Patient A's medical records from the Community Health Plan (CHP) were received at the ACCF. The

records indicated that the patient was a type I diabetic on a regimen of regular insulin. Respondent prescribed NPH insulin for the patient instead. Respondent testified that he did not prescribe regular insulin because he was afraid that the patient would develop hypoglycemia, since he was not compliant with his diet. Nonetheless, the patient did experience multiple episodes of hypoglycemia at night while on the NPH insulin, and also experienced high blood glucose levels during the day.

On September 10, 1997, Patient A was referred to Dr. El Deiry for a consultation. Dr. El Deiry recommended discontinuance of the NPH insulin, in favor of a sliding scale regimen of regular insulin and an oral medication, with a one-week follow-up. Respondent rejected these recommendations. He claimed, without justification, that the patient would somehow use the regular insulin to harm himself, and that regular insulin would cause large drops in the patient's blood sugar. These claims were without rational basis in fact.

The Hearing Committee unanimously concluded that Respondent's medical care and treatment of Patient A's diabetes demonstrated both negligence and incompetence, as defined above. They further concluded that it did not rise to a level warranting a finding of either gross negligence or gross incompetence.

On August 2, 1997, Patient A complained of severe stomach pain and cramping, diarrhea and weight loss, all of which was reported to Respondent. These symptoms are consistent with appendicitis. To make a diagnosis of appendicitis, one must rule out other differential diagnoses. Respondent should have obtained a detailed history and physical examination to determine the exact nature and location of the pain, and assess the condition of the abdomen. He should also have ordered blood chemistry studies.

However, Respondent failed to perform or order the performance of the history and physical. He also failed to order appropriate laboratory studies. Respondent did see the patient two days later, on August 4th. There is no indication in the patient's medical record that he performed any history or physical regarding the abdominal complaints. Ms. Voland did, however, hear Respondent yelling at Patient A, while he was observed to be bent over at the waist, and holding his waist with his hands.

Prior to seeing Patient A on August 4, 1997, Respondent was informed that the patient had difficulty in walking up the stairs to the medical unit, and was found lying on the stairs. Rather than perform an examination of the patient, Respondent accused Patient A of faking his lethargy,

and referred him to the mental health unit. Two days later, Respondent again saw the patient, who appeared disheveled. Again, Respondent took no history or physical, and ordered no laboratory studies.

On August 8, 1997, Nurse Voland informed Respondent by telephone that Patient A was diaphoretic; his skin was clammy; his clothes were covered with his own feces, his toilet contained unflushed diarrhea, and the patient was unable to get out of bed. Respondent ordered the patient to get out of bed and clean himself and his cell. Respondent testified that he did not consider the patient to be in an emergent condition. On the contrary, Respondent stated that he felt the patient was faking his symptoms (*See*, T. 661, 690). Ultimately, the ACCF staff ordered Patient A's transfer to AMCH. Once at the hospital, Dr. Lee found that Patient A was in acute distress. Dr. Lee operated on the patient and determined that he had a ruptured appendix, with a liter of purulent material in the abdomen. The quantity and consistency of purulent material was consistent with a perforation which had been present for several days before surgery.

The Hearing Committee concluded that Respondent's failure to appropriately diagnose and treat Respondent's developing appendicitis demonstrated negligence as defined

previously, but was not so egregious as to warrant a finding of gross negligence. As a result, the Committee did not sustain the First Specification (by a vote of 2 - 1). The Committee further unanimously concluded that Respondent's conduct did not demonstrate a lack of the skill or knowledge requisite to a finding of incompetence. As a result, the Committee did not sustain the Second Specification (gross incompetence). The Hearing Committee further concluded that Respondent failed to maintain an accurate record for Patient A, and voted to sustain the Fifth Specification.

Patient B

Respondent provided medical care to Patient B, a 43 year old female, during the period including July 8, 1998 through July 15, 1998 at the ACCF. Throughout her course of treatment at the ACCF, Patient B complained of headaches. On June 30, 1998, Patient B was seen by the physician's assistant, who noted complaints of slurred speech, difficulty remembering words and an "unusual feeling". Respondent saw the patient on July 8, 1998. He testified that he was likely aware of these complaints when he saw the patient. However, there is no mention of these complaints in his note for the July 8 patient encounter. The entry notes "multiple complaints", including left knee and vaginal discharge.

Five days later, Respondent again saw Patient B. He noted slurred speech and an inability to concentrate, yet he again failed to conduct or order any appropriate tests. He assumed that the patient's symptoms were caused by medications which the patient was taking, yet failed to make any attempt to rule out other causes. Ultimately, it was determined that Patient B was terminally ill.

The Hearing Committee recognizes that earlier detection of Patient B's condition by Respondent would not have altered the ultimate outcome. Nevertheless, at the time, the full extent of the patient's condition was unknown. Respondent was obligated to comply with generally accepted standards of medical practice in assessing the patient. He failed to do so. The Committee concluded that Respondent's conduct toward Patient B demonstrated negligence, as defined above. The Committee further concluded that a finding of incompetence was not warranted by the circumstances.

Based upon the foregoing, the Hearing Committee unanimously voted to sustain the Third Specification (negligence on more than one occasion), and to dismiss the Fourth Specification (incompetence on more than one occasion).

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be suspended for a period of six months, with said suspension stayed, and Respondent placed on probation for a period of one year from the effective date of this Determination and Order. The terms of probation are attached to this Determination and Order in Appendix II and incorporated herein. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent's conduct warrants a sanction. He ignored clear evidence of significant changes in the condition of two patients under his care. The difficult working conditions present at the Albany County Correctional Facility do not excuse his failure to provide minimally acceptable care. Counsel for Petitioner has recommended that Respondent receive an actual suspension of six months.

The Hearing Committee considered this recommendation carefully. The Committee also took into account the fact that

Respondent is no longer the medical director at the ACCF and that no allegations were raised concerning the care rendered by Respondent to any of his private practice patients. The Hearing Committee believes that the likelihood of a repetition of Respondent's misconduct is relatively low. Under the circumstances, the Hearing Committee unanimously determined that a six month stayed suspension, with a concurrent year of probation, will strike the appropriate balance between the need to punish Respondent for his actions, and protect the public from any future misdeeds.

ORDER

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

1. The Third and Fifth Specifications of professional misconduct, as set forth in the Statement of Charges, (Petitioner's Exhibit #1) are **SUSTAINED**;

2. The First, Second, and Fourth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **SUSPENDED** for a period of six (6) months commencing on the effective date of this Determination and Order. Said suspension shall be stayed, and Respondent shall be placed on probation for a period of one

(1) year from the effective date of this Determination and Order. The complete terms of probation are attached to this Determination and Order in Appendix II and incorporated herein;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Troy, New York
January 10 ,2001

Donald Cherr

DONALD CHERR, M.D. (CHAIR)

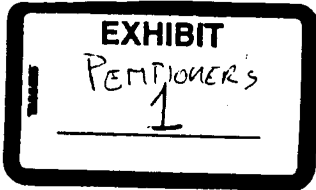
HRUSIKESH PARIDA, M.D.
JOHN O. RAYMOND

TO: Lee A. Davis, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower Building - Room 2509
Empire State Plaza
Albany, New York 12237

J. ARTHUR ~~Artur~~ Torian, M.D.
821 Second Avenue
Troy, New York 12182

Carolyn Shearer, Esq.
Hinman, Straub, Pigors & Manning, P.C.
121 State Street
Albany, New York 12207-1622

APPENDIX I



STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

---X

IN THE MATTER	: **NOTICE**
OF	: **OF**
JAMES ARTHUR TORIAN, M.D.	: **HEARING**

---X

TO: JAMES ARTHUR TORIAN, M.D.
821 SECOND AVE.
TROY, NEW YORK 12182

180 LENOX AVE.
ALBANY, NEW YORK 12208

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. 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 22nd of June, 2000, at 10:00 in the forenoon of that day at the Quality Inn, I-90 & Everett Road, Albany, New York 12206 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 Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), 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(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy 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. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
May 19, 2000

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Lee A. Davis
Assistant counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

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

---X

IN THE MATTER OF JAMES ARTHUR TORIAN, M.D.	:	STATEMENT OF CHARGES

---X

JAMES ARTHUR TORIAN, M.D., the Respondent, was authorized to practice medicine in New York State on October 16, 1969, by the issuance of license number 105059 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through November 30, 2000, with a registration address of 821 Second Avenue, Troy, New York 12182.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a male patient 26 years old when treated, at various times during the period of July 14, 1997 through November 6, 1997 at the Albany County Correctional Facility, Albany, New York (hereafter, "ACCF"). Respondent was the Medical Director of the ACCF. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent, between July 14, 1997 and July 29, 1997, failed to order and/or document the ordering of any insulin for Patient A, despite: (a) the patient's documented medical history as an insulin dependent

diabetic since childhood; (b) the patient's documented medical history as currently on a prescribed insulin regimen upon admission to ACCF; and/or (c) the patient's repeated experience of hyperglycemia (elevated blood glucose levels) during this period in the absence of insulin.

amended by Pet. 7/13/2000 JJS

2. Respondent, between July 30, 1997 and ~~October 1,~~ September 29, 1997, failed to properly evaluate and manage, and/or record the proper evaluation and management of Patient A's insulin dependent diabetes, in light of the patient's history, symptoms and complaints.

3. Respondent, between July 30, 1997 and August 8, 1997, despite the patient's reported history of severe abdominal cramps, bloody stools, diarrhea and weight loss, failed to order and/or record the ordering of medically indicated diagnostic tests, including a CBC, blood chemistries, or blood amylase, to rule out, among other things, that Patient A had suffered a perforated appendix.

4. Respondent, between August 2, 1997 and August 8, 1997, failed to perform and/or record and/or order an adequate physical examination of Patient A in light of the patient's complaints and symptoms.

5. Respondent, when informed on August 8, 1997 that Patient A had been suffering at least 6 days of severe abdominal pain, and that the patient was currently "clammy", hypotensive and experiencing severe diarrhea, failed to perform or order a physical examination of Patient A, and/or failed to document the performance or ordering of such examination.

6. Respondent, without medical justification and/or without recording such justification, failed to follow the September 11, 1997 recommendation of a consulting endocrinologist that Patient A commence an oral hypoglycemic agent and use a regular insulin scale.

B. Respondent provided medical care and treatment to Patient B, a female patient 43 years old when treated, at the ACCF, Albany, New York, while Respondent was the Medical Director of the ACCF. Respondent treated Patient B from July 8, 1998 through July 15, 1998 after she had complained of a variety of ailments, including headaches, slurred speech and lack of concentration. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent, between July 8, 1998 and July 21, 1998, failed to perform and/or order the performance of an adequate physical examination of Patient B, and/or failed to record the performance or ordering of an adequate physical examination of Patient B.

2. Respondent, between July 8, 1998 and July 21, 1998, failed to perform and/or order the performance of an adequate neurological examination of Patient B, and/or failed to record the performance or ordering of an adequate neurological examination of Patient B.

amended by Pet. 08/08/2000 JGB

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts set forth in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6.

SECOND SPECIFICATION
GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence on a particular occasion, in that Petitioner charges the following:

2. The facts set forth in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5 and/or A and A.6.

THIRD SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges Respondent committed two or more of the following:

3. The facts set forth in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1 and/or B and B.2.

FOURTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) by reason of his practicing the profession of medicine with incompetence on more than one

occasion, in that Petitioner charges Respondent committed two or more of the following:

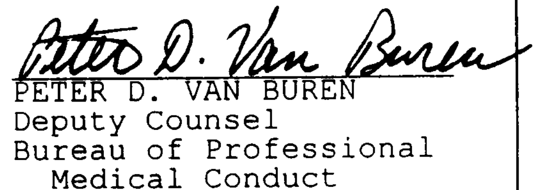
4. The facts set forth in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1 and/or B and B.2.

FIFTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges the following:

5. The facts set forth in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1 and/or B and B.2.

DATED: May 19, 2000
Albany, New York



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

APPENDIX II

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession. Respondent acknowledges that if he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.