STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

February 7, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Richard J. Zahnleuter, Esq.
NYS Department of Health
ESP – Corning Tower – Room 2512
Albany, New York 12237

Jatinder S. Bakshi, M.D.
[Redacted] Address
[Redacted]

Kenneth B. Schwartz, Esq.
555 Westbury Avenue
Carle Place, New York 11514

RE: In the Matter of Jatinder S. Bakshi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-22) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent 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,

Redacted Signature
James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
JATINDER S. BAKSHI, M.D.	:	ORDER
		BPMC #08-22

A Notice of Hearing and Statement of Charges, both dated March 1, 2007, were served upon the Respondent, Jatinder S. Bakshi, M.D. **LYON M. GREENBERG, M.D. (CHAIR), RAVINDER MAMTANI, M.D., AND MARY ANN CRESANTI, N.P.,** 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 Richard J. Zahnleuter, Esq., Associate Counsel. The Respondent appeared by Kenneth B. Schwartz, Esq. 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.

PROCEDURAL HISTORY

Date of Service:	March 29, 2007
Answer Filed:	April 25, 2007
Pre-Hearing Conference:	May 5, 2007
Hearing Dates:	May 30, 2007 June 28, 2007 August 2, 2007 August 3, 2007 August 21, 2007 September 26, 2007
Witnesses for Petitioner:	Andrew Dubin, M.D.
Witnesses for Respondent:	Ranga C. Krishna, M.D. Jatinder S. Bakshi, M.D.
Deliberations Held:	November 20, 2007

STATEMENT OF CASE

Petitioner has charged Respondent with seventeen specifications of professional misconduct. The charges relate to Respondent's medical care and treatment of five patients. The charges include allegations of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, and failing to maintain accurate medical records. Respondent denied the allegations.

A copy of the 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.

General Findings

1. Jatinder S. Bakshi, 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 196731 on or about August 2, 1984. (Ex. #4).

2. Respondent completed a residency in neurology in 1995, but is not board-certified in that field. (T. 777-779, 985).

3. Respondent has been engaged in the private practice of medicine, specializing in neurology, since 1995. (T. 779).

4. Andrew H. Dubin, M.D. testified on behalf of the Department in this matter. Dr. Dubin is board-certified in physical medicine and rehabilitation. He is also board-certified in electrodiagnostic medicine by the American Board of Electrodiagnostic Medicine (now the American Academy of

Neuromuscular Electrodiagnostic Medicine "AANEM"). (T. 22; Ex. #14).

5. Dr. Dubin is an associate professor of physical medicine and rehabilitation at the Albany Medical College, as well as the director of residency education for the department of physical medicine and rehabilitation at the Albany Medical Center Hospital. (Ex. #14).

6. Dr. Dubin spends approximately 85-90% of his time in active patient care. (T. 47).

7. Ranga C. Krishna, M.D. testified on behalf of the Respondent. Dr. Krishna is board-certified in neurology, and is a member of the American Academy of Electrodiagnostic Medicine. Dr. Krishna has maintained a private practice in neurology and neurophysiology since 1994. (T. 533-534; Ex. F).

8. During a period of time in the 1990's, Dr. Krishna was a co-owner (with Respondent) of a professional corporation entitled Pelham Professional Medical Corporation. (T. 672-673).

9. Dr. Krishna is a personal friend of Respondent. (T. 674).

Patient A

10. Respondent evaluated and treated Patient A, a forty-three year old male, beginning on December 5, 2000, for injuries that Patient A sustained in a motor vehicle accident on November 1, 2000. The patient was first seen on December 5, 2000. (Ex. ##20, 21, 22).

11. The original neurological consultation was performed by a Dr. Dawoodie. (ALJ Ex. #2). A typed version of the consultation report was subsequently prepared, and signed by Respondent. (Ex. #20, pp. 15-18).

12. The process of eliciting and documenting an adequate history is necessary so the physical regions of the body in question can be focused upon, the necessary electrodiagnostic tests can be performed with proper insight and objectives, and the data interpreted and assessed for concordance. (T. 90-91, 148-151).

13. It is important to elicit, organize and document information about the mechanism of injury and force of impact, time frame of the development and progression of pain, and status of bowel and bladder function. (T. 63-66, 76-80, 92-93).

14. Respondent's initial consultation for Patient A (as well as the remaining patients) was recorded on a pre-

printed form. This form contains pre-recorded information regarding the nature of a patient's injury, history, symptoms. Items are then either circled, underlined, checked or left unmarked. Examination findings are similarly pre-printed. Diagnostic impressions are also pre-printed, with pertinent items marked with a check. (Ex. ALJ #2).

15. The consultation form was then transcribed into a typed document. (Ex. #20, pp. 15-18).

16. Respondent's history failed to elicit and document information concerning the mechanism of injury and force of impact, as well as the status of the patient's bowel and bladder function. (T. 146-151; Ex. # 20; ALJ. #2).

17. Patient A completed an initial intake form, dated December 4, 2000 in which he indicated that he had missed five days of work immediately following his motor vehicle accident. (Ex. #20, p. 10).

18. Dr. Dawoodie noted on the neurological consultation form that the patient was currently working. Dr. Dawoodie also determined that the patient was "temporary totally disabled". (ALJ #2).

19. The diagnostic impressions regarding Patient A were: cervical muscle post traumatic sprain syndrome; lumbar post traumatic pain syndrome; traumatic herniation of the

cervical intervertebral disc (clinical impression); traumatic herniation of the lumbar intervertebral disc (clinical impression), and rule out cervical and lumbosacral radiculopathy. (ALJ Ex. #2; Ex. #20, p. 17).

20. The doctor recommended that Patient A undergo electrodiagnostic myography ("EMG") and nerve conduction velocity ("NCV") studies of the upper and lower extremities; MRI of the cervical and lumbar spine; computerized range of motion and muscle strength testing. He prescribed flexeril 10 mg. po bid and naprosyn po tid; physical therapy three times per week and to refrain from strenuous activities. (ALJ Ex. #2; Ex. #20, pp. 17-18).

21. Respondent's dictated and signed consultation report adopted all of Dr. Dawoodie's findings and recommendations. (Ex. #20, pp. 15-18).

22. Respondent performed electromyography and nerve conduction velocity studies of Patient A's upper extremities on January 5, 2001. Respondent noted that "There is a quiet baseline potential at rest in paraspinal muscles at rest". (Ex. #22).

23. On January 5, 2001, Respondent further noted that "Electromyography of the upper extremities reveals no electrical evidence of a cervical radiculopathy". (Ex. #22).

24. Respondent performed electromyography and nerve conduction velocity studies of Patient A's lower extremities on January 19, 2001. Respondent noted that "The paraspinal muscles also revealed a quiet resting potential". (Ex. #21).

25. On January 19, 2001, Respondent further noted that "Electromyography of the lower extremity muscles revealed no evidence of a lumbosacral radiculopathy". (Ex. #21).

26. Respondent prescribed flexeril and naproxyn for Patient A. He also ordered a TENS unit, and prescribed physical therapy, three times a week. (T. 665-668; Ex. #20).

27. Patient A continued physical therapy throughout Respondent's treatment of the patient. Respondent last saw the patient on March 9, 2001. At that time, he noted that the patient had shown little improvement. (Ex. #20).

28. On March 29, 2001, Patient A was evaluated by Gregg M. Szerlip, D.O. Dr. Szerlip is an anesthesiologist with a pain management practice. (T. 661-662; Ex. E, pp. 7-8).

29. Dr. Szerlip's consultation report indicates that the patient was referred to him by Respondent. Respondent's medical record for Patient A does not contain any evidence of a referral to Dr. Szerlip, and a copy of the report is not contained in the record. (Ex. #20; Ex. E, p. 7).

Patient B

30. Respondent evaluated and treated Patient B, a twenty-nine year old male, for injuries sustained in a motor vehicle accident on January 31, 2001. He first saw the patient on February 2, 2001. (Ex. ## 24 and 25).

31. Respondent's initial consultation for Patient B was recorded on a pre-printed form. This form contains pre-recorded information regarding the nature of a patient's injury, history, symptoms. Items are then either circled, underlined, checked or left unmarked. Examination findings are similarly pre-printed. Diagnostic impressions are also pre-printed, with pertinent items marked with a check. (Ex. #24, pp. 9-13).

32. The consultation form was then transcribed into a typed document. (Ex. #24, pp. 14-17).

33. Respondent's history failed to elicit and document information concerning the mechanism of injury and force of impact, as well as the status of the patient's bowel and bladder function. (Ex. # 24; Ex. #25).

34. Respondent's diagnostic impressions regarding Patient B were: post traumatic headache; cervical muscle post traumatic sprain syndrome; lumbar post traumatic sprain syndrome; traumatic herniation of the cervical intervertebral

disc (clinical impression); traumatic herniation of the lumbar intervertebral disc (clinical impression); rule out cervical radiculopathy; rule out internal derangement of left knee; left hand pain. (Ex. #25, p. 59).

35. Respondent recommended that Patient B undergo EMG and NCV studies of the upper extremities; MRI of the cervical lumbosacral region; x-ray of the left knee; orthopedic evaluation of the left knee; and computerized range of motion and muscle strength testing. Respondent further recommended physical therapy three times per week for the next four weeks, Advil as needed, and to refrain from strenuous physical activities. (Ex. #25, p. 60).

36. On February 23, 2001, Respondent performed EMG and NCV studies of Patient B's upper extremities. Respondent noted that "There is a quiet baseline potential at rest in paraspinal muscles at rest". Respondent further noted that "Electromyography of the upper extremities reveals no electrical evidence of a cervical radiculopathy". (Ex. #25, pp. 66-69).

37. On March 2, 2001, Respondent performed EMG and NCV studies of Patient B's lower extremities. Respondent noted that "Needle electromyography of lower extremities revealed a fibrillation potential in the bilateral L5-S1

distribution, a normal recruitment pattern and amplitude indicating a bilateral L5-S1 lumbosacral radiculopathy". He further noted that "There are some polyphasic waves in L5-S1, distribution bilaterally". (Ex. #25, p. 62).

38. Patient B continued physical therapy throughout Respondent's treatment of the patient. On September 12, 2001, Respondent noted that the patient had shown some limited improvement although he had experienced periods of remission and periods of exacerbation. (Ex. #25, p. 5).

39. Patient B was evaluated by Dr. Szerlip on February 1, 2001 - one day prior to being seen by Respondent. Dr. Szerlip's consultation report does not indicate that the patient was referred to him by Respondent. Respondent's medical record for Patient B does not contain any evidence of a referral to Dr. Szerlip, and a copy of the report is not contained in the record. (Ex. ## 24 and 25; Ex. E, pp. 2-3).

Patient C

40. Respondent evaluated and treated Patient C, a seventy-four year old male, for injuries suffered in a motor vehicle accident on November 19, 2000. He first saw the patient on November 28, 2000. (Ex. #26; Ex. #27).

41. Patient C was seen in the Franklin Hospital Center emergency room following the accident. Respondent did

not obtain a copy of the emergency room record, and include it in his office record for the patient. (Ex. #26; Ex. #27).

42. Respondent's initial consultation for Patient C was recorded on a pre-printed form. This form contains pre-recorded information regarding the nature of a patient's injury, history, symptoms. Items are then either circled, underlined, checked or left unmarked. Examination findings are similarly pre-printed. Diagnostic impressions are also pre-printed, with pertinent items marked with a check. (Ex. #26, pp. 48-52).

43. The consultation form was then transcribed into a typed document. (Ex. #26, pp. 40-43).

44. Respondent's history failed to elicit and document information concerning the mechanism of injury and force of impact, as well as the status of the patient's bowel and bladder function. (Ex. # 26, pp. 48-52).

45. Respondent's diagnostic impressions regarding Patient C were: cervical muscle post traumatic sprain syndrome; lumbar post traumatic sprain syndrome; traumatic herniation of the cervical intervertebral disc (clinical impression); traumatic herniation of the lumbar intervertebral disc (clinical impression); rule out cervical and lumbosacral radiculopathy. (Ex. #26, p. 42).

46. Respondent recommended that Patient C undergo EMG and NCV studies of the upper extremities, and MRI of the cervical and lumbosacral spine. He further recommended physical therapy three times per week for the next four weeks; follow-up in one month, and to refrain from strenuous physical activities. (Ex. #26, pp. 42-43).

47. On February 22, 2001, Respondent performed NCV studies of the patient's upper extremities. Respondent noted that "NCV/EMG of the upper extremity was negative for cervicular radiculopathy". (Ex. #26, p. 57).

48. On March 16, 2001, Respondent performed EMG and NCV studies of Patient C's lower extremities. Respondent noted that "The needle electromyography of lumbar paraspinal muscles revealed a quiet potential at rest". Respondent further noted that "Needle electromyography of lower extremities revealed polyphasic complexities in the bilateral L5-S1 distribution, a normal recruitment pattern and an increased amplitude indicating a bilateral L5-S1 chronic lumbosacral radiculopathy". Respondent further noted that "The electromyography revealed an evidence of a moderately severe bilateral L5-S1, chronic radiculopathy". (Ex. #26, p. 53).

49. Respondent prescribed physical therapy three times a week for the entire time that Patient C was being treated. Respondent saw Patient C for follow-up visits on January 16, February 21, and March 16, 2001. On each visit, Respondent noted that the patient had shown little improvement. (Ex. #26).

50. Patient C was evaluated by Dr. Szerlip on January 11 2001. Respondent's medical record for Patient C does not contain any evidence of a referral to Dr. Szerlip, and a copy of the report is not contained in the record. (Ex. # 26; Ex. E, pp. 4-6).

Patient D

51. Respondent evaluated and treated Patient D, a 59 year-old female, for injuries received in a motor vehicle accident on October 16, 2000. He first saw the patient on October 17, 2000. (Ex. #28).

52. Respondent's initial consultation for Patient D was recorded on a pre-printed form. This form contains pre-recorded information regarding the nature of a patient's injury, history, symptoms. Items are then either circled, underlined, checked or left unmarked. Examination findings are similarly pre-printed. Diagnostic impressions are also

pre-printed, with pertinent items marked with a check. (Ex. #28, pp. 13-17).

53. Respondent's history failed to elicit and document information concerning the mechanism of injury and force of impact, as well as the status of the patient's bowel and bladder function. (Ex. # 28, pp. 13-17).

54. Respondent's diagnostic impressions regarding Patient D were: post traumatic headache; cervical muscle post traumatic sprain syndrome; traumatic herniation of the cervical intervertebral disc, and rule out cervical radiculopathy. (Ex. #28, pp. 16-17).

55. Respondent recommended that Patient D undergo EMG and NCV studies of the upper extremities, x-rays and an MRI of the cervical spine. Respondent further recommended that Patient D receive physical therapy three times per week for four weeks. (Ex. #28, p. 17).

56. On November 17, 2000, Respondent performed EMG and NCV studies of Patient D's upper extremities. He noted that "Cervical paraspinal muscles revealed a fibrillation potential at rest". (Ex. #28, pp. 9-12).

57. On January 5, 2001, Respondent performed EMG and NCV studies of Patient D's lower extremities. He noted that "Needle Electromyography of lower extremities revealed

fibrillation potential in the left L5-S1 distribution, a normal recruitment pattern and amplitude indicating a left L5-S1 Lumbosacral radiculopathy". Respondent further noted that "Electromyography of the lower extremities revealed a left L5-S1 lumbosacral radiculopathy. (Ex. # 29, pp. 1-4).

58. Respondent prescribed physical therapy two or three times a week for the entire time that Patient D was being treated. Respondent saw Patient D for follow-up visits on November 28, and December 22, 2000, and January 5, February 13, March 16, 2001, and April 13, 2001. On each visit, Respondent noted that the patient had shown little or moderate improvement. (Ex. #26).

59. Patient D was evaluated by Dr. Szerlip on March 8, 2001. Respondent's medical record for Patient D does not contain any evidence of a referral to Dr. Szerlip, and a copy of the report is not contained in the record. (Ex. #28; Ex. E, pp. 9-11).

Patient E

60. Respondent evaluated and treated Patient E, a 77 year-old female, for injuries received in a motor vehicle accident on February 28, 2001. He first saw the patient on March 2, 2001. (Ex. #30, p. 25).

61. Respondent's initial consultation for Patient E was recorded on a pre-printed form. This form contains pre-recorded information regarding the nature of a patient's injury, history, symptoms. Items are then either circled, underlined, checked or left unmarked. Examination findings are similarly pre-printed. Diagnostic impressions are also pre-printed, with pertinent items marked with a check. (Ex. #30, pp. 25-29).

62. The consultation form was then transcribed into a typed document. (Ex. #30, pp. 30-33).

63. Respondent's history failed to elicit and document information concerning the mechanism of injury and force of impact, as well as the status of the patient's bowel and bladder function. (Ex. # 30, pp. 30-33).

64. Respondent's diagnostic impressions regarding Patient E were: post-traumatic headache; cervical muscle post traumatic sprain syndrome; lumbar post traumatic sprain syndrome; traumatic herniation of the cervical intervertebral disc (clinical impression); traumatic herniation of the lumbar intervertebral disc (clinical impression); rule out cervical and lumbosacral radiculopathy, and right hand pain. (Ex. #30, p. 32).

65. Respondent recommended that Patient E undergo EMG and NCV studies of the upper and lower extremities; MRI of the cervical and lumbosacral spine; computerized range of motion and muscle strength testing; physical therapy three times per week for the next four weeks, and to refrain from strenuous physical activities. (Ex. #30, p. 33).

66. Respondent performed EMG and NCV studies of Patient E's upper extremities on April 20, 2001. Respondent noted that "Cervical paraspinal muscles also revealed a fibrillation potential at rest". Respondent further noted that "The needle electromyography of the upper extremities revealed an evidence of a left C5-6, cervical radiculopathy. There is normal insertional activity, a fibrillation potential in the left C5-6, distribution at rest, a normal amplitude and recruitment". Respondent further noted that "There is an electromyographic evidence of a left C5-6, cervical radiculopathy". (Ex. #30, pp. 15-18).

67. Respondent performed EMG and NCV studies of Patient E's lower extremities on April 27, 2001. Respondent noted "Posterior Tibial H-reflex revealed a normal response bilaterally". Respondent further noted that "Sural sensory nerve distal latency revealed abnormal response on the left side". Respondent further noted that "The needle

electromyography of lumbar paraspinal muscles revealed a quiet potential at rest. Electromyography of lower extremities revealed polyphasic complexes in the bilateral L5-S1, distribution, a decreased recruitment pattern and amplitude indicating a bilateral L5-S1, lumbosacral radiculopathy". Respondent further noted that " The lower extremity nerves tested revealed normal latencies, amplitude and conduction velocity". Respondent further noted that "Left sural sensory response is abnormal. There is an electrical evidence of a peripheral neuropathy in this lower extremity nerve study". Respondent further noted that "The electromyography revealed an evidence of a moderately severe bilateral L5-S1, lumbosacral radiculopathy". (Ex. #30, pp. 19-22).

68. Respondent saw the patient on April 6, 2001. He noted that she had shown little improvement. He prescribed additional physical therapy three times per week for four weeks, and Vioxx. (Ex. #30, pp. 34-35).

69. Dr. Szerlip evaluated Patient E on May 3, 2001. He recommended that the patient undergo a series of lumbar epidural steroid ("LES") and cervical epidural steroid ("CES") injections. Respondent's medical record for Patient E does not contain any evidence of a referral to Dr. Szerlip, and a

copy of the report is not contained in the record. (Ex. #30; Ex. D).

70. Respondent next saw the patient on May 4, 2001. He noted that she had shown little improvement, and again prescribed physical therapy three times per week for four weeks. No reference is made to Dr. Szerlip's evaluation and treatment recommendations. (Ex. #30, pp. 39-41).

71. Dr. Szerlip administered LES injections to Patient E on May 10, May 24, and June 7, 2001. He administered CES injections to the patient on June 14 and 21, 2001. (Ex. D).

72. Respondent saw Patient E on June 1, 2001. He noted that the patient received physical therapy and diagnostic tests which he had previously ordered. No mention is made of the LES injections administered by Dr. Szerlip. Respondent again prescribed physical therapy three times per week for four weeks and Vioxx. (Ex. #30, pp. 45-46).

73. Dr. Szerlip administered CES injections to Patient E on June 14 and 21, 2001. (Ex. D).

CONCLUSIONS OF LAW

Respondent is charged with seventeen 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 the 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, and incompetence.

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). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

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.

Respondent is also charged with five specifications of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of N.Y. Education Law §6530(32). The Hearing Committee interpreted these allegations in light of the usual and commonly understood meaning of the terms. (*See*, New York Statutes, §232).

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. The Department presented testimony by Andrew H. Dubin, M.D.

Dr. Dubin is board-certified in physical medicine and rehabilitation (physiatry). He is also board-certified in electrodiagnostic testing by the American Academy of Neuromuscular Electrodiagnostic Medicine ("AANEM"). (T. 22, 25, 33, 141; Ex. #14). Dr. Dubin is an associate professor of physical medicine and rehabilitation at the Albany Medical College, and director of residency education in the department

of physical medicine and rehabilitation at the Albany Medical Center Hospital. (Ex. #14). Dr. Dubin also maintains an active private practice. He does not know the Respondent personally, and has no stake in the outcome of the case.

Dr. Dubin is an extremely well-qualified physical medicine and rehabilitation specialist. However, he is, to a greater extent, an academic physician. Even though he practices in the community, he acknowledged that he thinks like an academic. (T. 163). As a result, the Committee believes that his opinions as to community standards of care may not reflect general community standards.

Of greater concern to the Committee, however, is the fact that Dr. Dubin does not practice in the same field of medicine (neurology) as the Respondent. Dr. Dubin asserted that Respondent practices primarily within the area of neuromusculoskeletal medicine, and thus within the domain of physiatry. (T. 139-140). However, both neurologists and physiatrists evaluate and treat neuromuscular conditions. Dr. Dubin's somewhat dogmatic approach to the cases in question somewhat diminished his credibility.

Respondent presented testimony by Ranga C. Krishna, M.D. Dr. Krishna is a board-certified neurologist. He is also a member of the American Academy of Electrodiagnostic Medicine,

and practices neurology and neurophysiology in Brooklyn, New York. (Ex. F).

Dr. Krishna appears to be a highly competent neurologist. However, he is a personal friend of Respondent and has had business relationships with him. (T. 538-539, 674). It was quite evident from his testimony (which included numerous personal attacks on Dr. Dubin), that his objectivity was subject to question. This tended to diminish his credibility as well.

Lastly, Respondent testified on his own behalf. He has an obvious stake in the outcome of these proceedings, and the Committee evaluated his testimony accordingly. The Hearing Committee was concerned with the numerous inconsistencies in Respondent's testimony.

Respondent testified with regard to the testing of paraspinal muscles in Patient A that it was his standard procedure to put the test data in the tabular portion of the EMG report. (T. 943-944, 948). He then blamed the absence of the data on the technician assisting him. (T. 943, 949). With regard to Patients B and C, Respondent claimed that it was his standard procedure to merely document the results in the narrative portion of the EMG report. (T. 1159-1160). When confronted with paraspinal EMG results reported in the tabular portion of the upper extremity study on Patient D, Respondent

testified that it was his procedure to do so only when there were positive findings. (T. 1299, 1300-1302). Respondent gave similarly inconsistent explanations with regard to Patient E's EMG studies.

Respondent similarly blamed others (office staff) for the failure to document any of the pain management referrals in any of the patient records. The large number of inconsistencies, combined with the Respondent's tendency to blame others, diminished his credibility.

The Department's allegations against Respondent fall into four broad areas: the adequacy of the patient histories; the adequacy of the electrodiagnostic testing performed by Respondent; the alleged failure to discontinue physical therapy and/or substitute other modes of treatment, and the alleged failure to individualize treatment plans for each patient.

Patient Histories

It is undisputed that an adequate history is an essential element of evaluating a patient's condition, and developing an appropriate treatment plan. Respondent's histories for Patients A through E are deficient in several respects. There is inadequate information concerning the mechanism of injury and the force of impact in each case. Moreover, there is no information obtained regarding any changes

in bowel or bladder function following the patients' accidents. This information is critical when evaluating possible neurological injuries.

There is another, more fundamental deficiency in the histories documented by Respondent. There is a typed initial evaluation charted for each patient. Upon a casual reading, they appear to be comprehensive reviews of the patient's history, present complaints, and neurological examination. For example, Patient C's initial evaluation can be found in Exhibit #26, at pages 44-47. However, these typed reports are based on a "canned" evaluation form. (For illustrative purposes, the "original" initial evaluation for Patient C is attached to this Determination and Order in Appendix II).

Nearly all of the information contained in the evaluation is pre-printed, leaving the Respondent to merely check, or circle items which may be pertinent. The section of the evaluation labeled "neurological examination" is pre-printed in narrative form, and then merely carried over onto the typed version.

Respondent's over-reliance on pre-printed forms is no substitute for an appropriate history, focused on the particular patients background and complaints. We take note that the initial evaluation for Patient A was actually obtained by a Dr.

Dawoodie. However, by signing the typed report, Respondent accepted responsibility for this patient's history as well as the others.

Based on the foregoing, the Hearing Committee unanimously voted to sustain Factual Allegations I.1, J.1, K.1, L.1, and M.1.

The Department also alleged that Respondent's determination that Patient A was temporarily totally disabled was not supported by the documentation in the record. As noted previously, the initial evaluation of Patient A was performed by Dr. Dawoodie. Under these circumstances the Committee declined to sustain Factual Allegation I.2.

Electrodiagnostic Testing

The allegations raised by the Department regarding the EMG and NCV studies performed by Respondent are most troubling to the Hearing Committee. The experts presented by both parties presented opinions which were diametrically opposed in virtually every respect. According to Dr. Dubin, the studies performed were inadequate on both technical grounds, and due to a failure to test sufficient numbers of muscles. According to Dr. Krishna, the studies performed were acceptable in every aspect.

Both experts are knowledgeable in their respective fields. Both have substantial experience in electrodiagnostic

studies. Both cannot be right. However, for the reasons discussed below, we conclude that the Department has failed to meet its burden of proof on this subject.

Dr. Dubin's principal objection to the studies performed by Respondent derives from his opinion that Respondent did not test sufficient numbers of muscles. In particular, he rejected Respondent's reports of paraspinal muscle testing since it was generally not reflected in the tabular data section of the EMG reports. However, Dr. Krishna noted that the data is observed in real time, and may not be recorded by the testing equipment. The clinician listens to the signals generated and observes the wave patterns on a monitor. This opinion is corroborated by a recommended policy statement issued by the American Association of Neuromuscular & Electrodiagnostic Medicine (Ex. H). The AANEM statement indicates that needle EMG studies are interpreted in real time and that most EMG machines are unable to permanently copy the sounds produced, and that it is difficult and expensive to permanently copy needle EMG tracings. (Ex. H, p. 7).

In addition, Dr. Dubin's opinions regarding the minimum number of muscles which needed to be tested were informed, in large part, by research performed and reported by Timothy Dillingham, M.D., *et al.* (*See*, Ex. A, B and C). The

principal research article underpinning his testimony was published in the American Journal of Physical Medicine and Rehabilitation, in February, 2001. (Ex. A). However, this study would not have been widely known as a standard of practice to practitioners such as Respondent (a neurologist) at the time he treated Patients A through E. (T. 1505, 1509).

Based on the above, the Hearing Committee does not believe that the Department has established by a preponderance of the evidence, that the electrodiagnostic studies performed by Respondent failed to meet minimum standards. Accordingly, the Committee did not sustain Factual Allegations I.3-I.6, J.2-J.6, K.2-K.5, L.2-L.4, and M.2-M.13.

Physical Therapy

The Department has alleged that Respondent failed to discontinue physical therapy and/or substitute other modes of treatment after months of little or no improvement by each of the five patients. Dr. Dubin acknowledged that physical therapy is a reasonable and conservative approach to treating musculoskeletal pain. (T. 126). He opined, however, that after several months of therapy, alternative modalities of treatment, such as a pain management, should have been considered. He found no evidence of such referrals in the patient's medical records.

At the hearing, Respondent produced copies of consultation reports by Gregory Szerlip, D.O., a pain management specialist, for each of the five named patients. (Ex. D and E). Following their evaluations, Dr. Szerlip recommended continued physical therapy. He also recommended epidural injections for Patients A, C and E. Patients A and C declined the treatments. (Ex. E). Patient E did undergo a series of epidural injections. (Ex. D).

The Committee considered the authenticity of the consultation reports, insofar as they were not included in the medical records. In the absence of any evidence to the contrary, the Committee concluded that the reports were presumptively genuine. Our concerns regarding the absence of any reference to these reports in the charts will be discussed further, below. However, based upon the information contained therein, the Committee concluded that the Department has not carried its burden of proof regarding the issue of continued physical therapy by Respondent. Accordingly, the Committee did not sustain Factual Allegations I.7, J.7, K.6, L.5 and M.14.

Individualized Treatment Plans

The essence of the Department's allegations of a failure to individualize treatment plans is a claim that Respondent never adapted, altered or reacted to his treatment

plans. Dr. Dubin did not dispute the propriety of the diagnostic procedures performed (although he did dispute their findings), or the use of physical therapy. He opined that Respondent used a formulaic approach that did not vary.

However, the records do establish that in addition to physical therapy, Respondent did order varying medications for the patients, did order orthopedic appliances where appropriate, and did refer the patients for additional consultations. Accordingly, the Committee concluded that the Department has failed to prove that Respondent failed to individualize his treatment plans for the patients. Therefore, the Committee did not sustain Factual Allegations I.8, J.8, K.7, L.6 and M.15.

Specifications

Failure to Maintain Records

The evidence established that Respondent produced poorly documented, formulaic patient histories. Important information such as force and mechanism of impact, and changes in bowel and bladder function were not obtained. In addition, the records contained no evidence of any referrals to Dr. Szerlip, or the reports prepared by Dr. Szerlip. Accordingly, the Committee concluded that Respondent failed to maintain a record for Patients A through E that accurately reflected the evaluation and treatment of the patients, in violation of N.Y.

Education Law §6530(32). As a result, the Committee unanimously voted to sustain the Seventeenth through Twenty-First Specifications of professional misconduct set forth in the Statement of Charges.

Negligence on More Than One Occasion

Incompetence on More Than One Occasion

As noted above, the histories obtained and documented by Respondent were inadequate. The records were devoid of any information regarding the referrals to Dr. Szerlip, or the results of those referrals. As a result, Respondent's ability to coordinate his treatment decisions with those of Dr. Szerlip was inadequate. The Hearing Committee unanimously concluded that Respondent's failures in this regard constitute a lack of skill and knowledge necessary to the practice of the profession, as well as a failure to act as a reasonably prudent practitioner would under the circumstances. The Committee therefore concluded that Respondent's conduct with regard to Patients A through E constituted negligence on more than one occasion, in violation of N.Y. Education Law §6530(3), as well as incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5). As a result, the Committee voted to sustain the Fifteenth and Sixteenth Specifications of professional misconduct.

Gross Negligence

Gross Incompetence

The Hearing Committee unanimously concluded that Respondent's misconduct did not rise to the level of gross negligence or gross incompetence, as described above. Therefore, the Committee voted to dismiss the Fifth through Fourteenth Specifications of professional misconduct.

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 eighteen months. The suspension shall be stayed, and Respondent placed on probation for eighteen months. The terms of probation shall include a requirement that Respondent's records be monitored for accuracy and completeness. 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 practice is wholly unsupervised. There is no evidence that he is on the staff of any hospital which

might monitor his patient care. The Committee strongly believes that Respondent's history-taking and record-keeping should be monitored for a period of time to ensure that he maintains the standards of the profession. Therefore, the Committee determined that a period of probation with monitoring is necessary to ensure that Respondent can comply with applicable standards of practice. The Committee also determined that a period of suspension, albeit stayed, is necessary to demonstrate to Respondent the seriousness of his deficiencies.

ORDER

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

1. The Fifteenth, Sixteenth and Seventeenth through Twenty-First Specifications of professional misconduct, as set forth in the Statement of Charges, (Exhibit #2A) are **SUSTAINED**;

2. The Fifth through Fourteenth 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 **EIGHTEEN (18) MONTHS**. The suspension shall be **STAYED** and the Respondent placed on probation for a period of **EIGHTEEN (18) MONTHS**. The complete terms of probation are attached to

this Determination and Order in Appendix III, and incorporated by reference 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
February 5 **,2008**

Redacted Signature

LYON M. GREENBERG, M.D. (CHAIR)

RAVINDER MAMTANI, M.D.
MARY ANN CRESANTI, N.P.

TO: Richard J. Zahnleuter, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2512
Empire State Plaza
Albany, New York 12237

Jatinder S. Bakshi, M.D.

Redacted Address

Kenneth B. Schwartz, Esq.
555 Westbury Avenue
Carle Place, New York 11514

APPENDIX I

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

IN THE MATTER

OF

JATINDER S. BAKSHI, M.D.

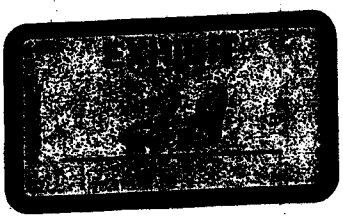
STATEMENT

OF

CHARGES

Jatinder S. Bakshi, M.D., referred to hereafter as the Respondent, was authorized to practice medicine in the State of New York on August 2, 1984 by the issuance of license number 196731 by the New York State Education Department. The Respondent's current address, upon information and belief, is Redacted Address .

FACTUAL ALLEGATIONS



I. At a P.C. known as Neurological Services of Queens, P.C., which was established on October 13, 2000 by the Respondent as the sole shareholder, and as director and officer, the Respondent evaluated Patient A[1], beginning on December 5, 2000, for injuries that Patient A sustained in an automobile accident on November 1, 2000. The Respondent cared for Patient A by evaluating Patient A and devising and implementing a diagnosis and treatment plan. The Respondent's care of Patient A did not meet acceptable standards of medical care in that:

1. The Respondent failed to obtain and/or document an adequate history on December 5, 2000.
2. The determination the Respondent made on December 5, 2000 that Patient A was "temporarily totally disabled at this time" was not supported by the documentation set forth in the record.
3. The determination the Respondent made on January 5, 2001 that "There is a quiet baseline potential at rest in paraspinal muscles at rest" was not supported by the electromyography studies the Respondent conducted.
4. The determination the Respondent made on January 5, 2001 that "Electromyography of the upper extremities reveals no electrical evidence of a cervical radiculopathy" was not supported by the

[1]To preserve privacy throughout this document, patients are referred to by letter designation. An Appendix of Patient Names is attached hereto for appropriate recipients.

electromyography studies the Respondent conducted.

5. The determination the Respondent made on January 19, 2001 that "The paraspinal muscles also revealed a quiet resting potential" was not supported by the electromyography studies the Respondent conducted.

6. The determination the Respondent made on January 19, 2001 that "Electromyography of the lower extremity muscles revealed no evidence of a lumbosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.

7. The Respondent failed to discontinue physical therapy and/or substitute other modes of treatment on March 9, 2001 after months of little or no improvement.

8. The Respondent failed to individualize his treatment plan to this particular patient.

J. At Neurological Services of Queens, P.C., the Respondent evaluated Patient B, beginning on February 2, 2001, for injuries that Patient B sustained in an automobile accident on January 31, 2001. The Respondent cared for Patient B by evaluating Patient B and devising and implementing a diagnosis and treatment plan. The Respondent's care of Patient B did not meet acceptable standards of medical care in that:

1. The Respondent failed to obtain and/or document an adequate history on February 2, 2001.

2. The determination the Respondent made on February 23, 2001 that "There is a quiet baseline potential at rest in paraspinal muscles at rest" was not supported by the electromyography studies the Respondent conducted.

3. The determination the Respondent made on February 23, 2001 that

"Electromyography of the upper extremities reveals no electrical evidence of a cervical radiculopathy" was not supported by the electromyography studies the Respondent conducted.

4. The determination the Respondent made on March 2, 2001 that "Needle electromyography of lower extremities revealed a fibrilation potential in the bilateral L5-S1, distribution, a normal recruitment pattern and amplitude indicating a bilateral L5-S1, lumborsacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.

5. The determination the Respondent made on March 2, 2001 that "The needle electromyography revealed an evidence of a bilateral L5-S1, lumbrosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.

6. The determination the Respondent made on March 2, 2001 that "There are some polyphasic waves in L5-S1, distribution bilaterally" was not supported by the electromyography studies the Respondent conducted.

7. The Respondent failed to discontinue physical therapy and/or substitute other modes of treatment on June 8, 2001, August 7, 2001, and September 18, 2001 after months of little or no improvement.

8. The Respondent failed to individualize his treatment plan to this particular patient.

K. At Neurological Services of Queens, P.C., the Respondent evaluated Patient C beginning on November 28, 2000, for injuries that Patient C sustained in an automobile accident on November 19, 2000. The

Respondent cared for Patient C by evaluating Patient C and devising and implementing a diagnosis and treatment plan. The Respondent's care of Patient C did not meet acceptable standards of medical care in that:

1. The Respondent failed to obtain and/or document an adequate history on November 28, 2000.
2. The determination the Respondent made on February 22, 2001 that "NCV/EMG of the upper extremity was negative for cervicular radiculopathy" was not supported by the documentation set forth in the record.
3. The determination the Respondent made on March 16, 2001 that "The needle electromyography of lumbar paraspinal muscles revealed a quiet potential at rest" was not supported by the electromyography studies the Respondent conducted.
4. The determination the Respondent made on March 16, 2001 that "Needle electromyography of lower extremities revealed polyphasic complexities in the bilateral L5-S1 distribution, a normal recruitment pattern and an increased amplitude indicating a bilateral L5-S1 chronic lumborsacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.
5. The determination the Respondent made on March 16, 2001 that "The ectromyography revealed an evidence of a moderately severe bilateral L5-S1, lumbrosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.
6. The Respondent failed to discontinue physical therapy and/or substitute other modes of treatment on February 22, 2001 after months of little or no improvement.
7. The Respondent failed to individualize his treatment plan to this

particular patient.

L. At Neurological Services of Queens, P.C., the Respondent evaluated Patient D, beginning on October 17, 2000, for injuries that Patient D sustained in an automobile accident on October 16, 2000. The Respondent cared for Patient D by evaluating Patient D and devising and implementing a diagnosis and treatment plan. The Respondent's care of Patient D did not meet acceptable standards of medical care in that:

1. The Respondent failed to obtain and/or document an adequate history on October 17, 2001.
2. The determination the Respondent made on November 17, 2000 that "Cervical paraspinal muscles revealed a fibrilation potential at rest" was not supported by the electromyography studies the Respondent conducted.
3. The determination the Respondent made on January 5, 2001 that "Needle Electromyography of lower extremities revealed fibrilation potential in the left L5-S1 distribution, a normal recruitment pattern and amplitude indicting a left L5-S1 Lumbosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.
4. The determination the Respondent made on January 5, 2001 that "Electromyography of the lower extremities revealed a left L5-S1, Lumbosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.
5. The Respondent failed to discontinue physical therapy and/or substitute other modes of treatment on February 13, 2001, and March 16, 2001 after months of little or no improvement.
6. The Respondent failed to individualize his treatment plan to this

particular patient.

M. At Neurological Services of Queens, P.C., the Respondent evaluated Patient E, beginning on March 2, 2001, for injuries that Patient E sustained in an automobile accident on February 28, 2001. The Respondent cared for Patient E by evaluating Patient E and devising and implementing a diagnosis and treatment plan. The Respondent's care of Patient E did not meet acceptable standards of medical care in that:

1. The Respondent failed to obtain and/or document an adequate history on March 2, 2001.
2. The determination the Respondent made on April 20, 2001 that "Cervical paraspinal muscles also revealed a fibrilation potential at rest" was not supported by the electromyography studies the Respondent conducted.
3. The determination the Respondent made on April 20, 2001 that "The needle electromyography of the upper extremities revealed an evidence of a left C5-6, cervical radiculopathy. There is normal insertional activity, a fibrillation potential in the left C5-6, distribution at rest, a normal amplitude and recruitment" was not supported by the electromyography studies the Respondent conducted.
4. The determination the Respondent made on April 20, 2001 that "There is an electromyographic evidence of a left C5-6, cervical radiculopathy" was not supported by the electromyography studies the Respondent conducted.
5. The determination the Respondent made on April 27, 2001 that "Posterior Tibial H-reflex revealed a normal response bilaterally" was not supported by the electromyography studies the Respondent conducted.

6. The determination the Respondent made on April 27, 2001 that "Sural sensory nerve distal latency revealed abnormal response on the left side" was not supported by the electromyography studies the Respondent conducted.

7. The determination the Respondent made on April 27, 2001 that "The needle electromyography of lumbar paraspinal muscles revealed a quiet potential at rest" was not supported by the electromyography studies the Respondent conducted.

8. The determination the Respondent made on April 27, 2001 that "Electromyography of lower extremities revealed polyphasic complexes in the bilateral L5-S1, distribution, a decreased recruitment pattern and amplitude indicating a bilateral L5-S1, lumbosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.

9. The determination the Respondent made on April 27, 2001 that "The needle electromyography of lumbar paraspinal muscles revealed a quiet potential at rest" was not supported by the electromyography studies the Respondent conducted.

withdrawn by dept. 09/26/2007 gjs

10. The determination the Respondent made on April 27, 2001 that "The lower extremity nerves tested revealed normal latencies, amplitude and conduction velocity" was not supported by the electromyography studies the Respondent conducted.

11. The determination the Respondent made on April 27, 2001 that "Left sural sensory response is abnormal" was not supported by the electromyography studies the Respondent conducted.

12. The determination the Respondent made on April 27, 2001 that "There is an electrical evidence of a peripheral neuropathy in this

lower extremity nerve study" was not supported by the electromyography studies the Respondent conducted.

13. The determination the Respondent made on April 27, 2001 that "The electromyography revealed an evidence of a moderately severe bilateral L5-S1, lumbosacral radiculopathy" was not supported by the electromyography studies the Respondent conducted.

14. The Respondent failed to discontinue physical therapy and/or substitute other modes of treatment on June 1, 2001 after months of little or no improvement.

15. The Respondent failed to individualize his treatment plan to this particular patient.

SPECIFICATIONS OF MISCONDUCT

FIFTH THROUGH NINTH SPECIFICATIONS
(GROSS NEGLIGENCE)

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

5. The facts set forth in paragraphs I and/or I(1-8).
6. The facts set forth in paragraphs J and/or J(1-8).
7. The facts set forth in paragraphs K and/or K(1-7).
8. The facts set forth in paragraphs L and/or L(1-6).
9. The facts set forth in paragraphs M and/or M(1-15).

TENTH THROUGH FOURTEENTH SPECIFICATIONS
(GROSS INCOMPETENCE)

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

10. The facts set forth in paragraphs I and/or I(1-8).
11. The facts set forth in paragraphs J and/or J(1-8).
12. The facts set forth in paragraphs K and/or K(1-7).
13. The facts set forth in paragraphs L and/or L(1-6).
14. The facts set forth in paragraphs M and/or M(1-15).

FIFTEENTH SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in two or more of the following:

15. The facts set forth in paragraphs I, I(1-8), J, J(1-8), K, K(1-7), L, L(1-6), M, and/or M(1-15).

SIXTEENTH SPECIFICATION
(INCOMPETENCE ON MORE THAN ONE OCCASION)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in two or more of the following:

16. The facts set forth in paragraphs I, I(1-8), J, J(1-8), K(1-7), L, L(1-6), M, and/or M(1-15).

SEVENTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS
(FAILING TO MAINTAIN RECORDS)

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

17. The facts set forth in paragraphs I and/or I(1-8).
18. The facts set forth in paragraphs J and/or J(1-8).
19. The facts set forth in paragraphs K and/or K(1-7).
20. The facts set forth in paragraphs L and/or L(1-6).
21. The facts set forth in paragraphs M and/or M(1-15).

DATED: March 1, 2007
Albany, New York

Redacted Signature

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

APPENDIX II

CENTER FOR NEUROMUSCULAR & ORTHOPEDIC CARE

~~NEUROLOGICAL CONSULTATION~~ Initial Evaluation

RE: [redacted]

D.o.A. 11/19/2000

REPORT DATE: NOV 2 8 2000

PLEASE BE ADVISED THAT THE ABOVE NAMED PATIENT IS A [redacted] YEAR OLD Rt HANDED MALE / ~~FEMALE~~, WHO WAS REFERRED TO ME FOR THE PURPOSE OF A NEUROLOGICAL EVALUATION.

HISTORY OF ACCIDENT

THE PATIENT WAS THE DRIVER / PASSENGER OF A CAR THAT WAS INVOLVED IN A MOTOR VEHICLE ACCIDENT / WORK RELATED INJURY

THERE WAS NO LOSS OF CONSCIOUSNESS, BUT, THE PATIENT STATES HE / ~~SHE~~ ~~WAS DAZED, STUNNED AND CONFUSED.~~ ON IMPACT THE PATIENT REPORTED INJURIES TO THE HEAD, NECK, LOW BACK,

OTHER: Rt Shoulder

HE/~~SHE~~ WAS EVALUATED AT Good Samaritan HOSPITAL AND WAS RELEASED THE SAME DAY. WHEN THE SYMPTOMS PERSISTED, THE PATIENT WAS REFERRED TO OUR OFFICE FOR EVALUATION AND RELIEF TO THE SYMPTOMS.

PRESENT COMPLAINTS:

- SHARP TRANSIENT CONSTANT HEADACHES
- NECK STIFFNESS AND PAIN RADIATING TO THE BOTH LEFT / RIGHT ARM(S), SHOULDER(S), FOREARM(S), HAND(S)
- NUMBNESS, TINGLING, PARESTHESIA, WEAKNESS AND PAIN AROUND BOTH RIGHT / LEFT SHOULDER(S), ARM(S), FOREARM(S), ELBOW(S), HAND(S), FINGER(S)

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- THE NECK AND BACK PAIN EXACERBATED ~~BY VALSALVA~~ MANEUVERS
- CONSTANT INTERMITTENT PERSISTING LOWER BACK PAIN RADIATING DOWN TO THE BUTTOCK(S), HIP(S), THIGH(S), KNEE(S), LEG(S), FOOT /FEET, TOE(S)
- NUMBNESS, TINGLING, PARESTHESIA / WEAKNESS AND PAIN IN BOTH RIGHT AND LEFT HIP(S), KNEE(S), LEG(S), FOOT, FEET, TOE(S).

- ANXIETY
- TINNITUS
- DEPRESSION
- BLURRED VISION / DOUBLE VISION
- DIZZINESS - AGGRAVATED BY POSITIONAL CHANGE
- DIFFICULTY IN CONCENTRATION
- HEADACHES ASSOCIATED WITH DIMINISHED SENSE OF AWARENESS TO THE ENVIRONMENT ON A DAILY BASIS FOR 5-7 SECONDS / 10-15 SECONDS AT A TIME
- INSOMNIA
- VERTIGO
- OTHER: RT Shoulder & arm

PAST MEDICAL HISTORY:

- THERE IS NO SIGNIFICANT MEDICAL HISTORY. / THERE IS A HISTORY OF HYPERTENSION, DIABETES MELLITUS. / OSTEOARTHRITIS. /
- OTHER:

FAMILY HISTORY:

- UNREMARKABLE
- THERE IS A HISTORY OF CANCER, HEART DISEASE, DIABETES
- OTHER

ALLERGIES:

- PATIENT DENIES ANY ALLERGIES
- ALLERGY(IES)

SOCIAL HISTORY:

- PATIENT IS A NON / SMOKER, NON / ALCOHOL CONSUMING
- DRUGS
- ALCOHOL
- SMOKING Ex-Smoker

PATIENT WORKING STATUS Yes

OTHER

H9

HEAD, EARS, NOSE AND THROAT:

HEAD IS ATRAUMATIC AND NORMOCEPHALIC. PUPILS ARE EQUAL AND REACTIVE TO LIGHT AND ACCOMMODATION, AND EXTRAOCULAR MUSCLES WERE INTACT. THE EARS, NOSE, MOUTH AND THROAT WERE UNREMARKABLE.

EXTREMITIES:

ALL AREAS OF PERIPHERAL PULSES WERE PALPATED AND WITHIN NORMAL LIMITS

CERVICAL SPINE:

MODERATE SUBOCCIPITAL TENDERNESS AND MULTIPLE AREAS OF TENDERNESS ALONG THE CERVICAL SPINE, ESPECIALLY AT THE C 4-6 LEVEL(S), MORE SO ON THE Rt SIDE. PARASPINAL MUSCLE SPASM WAS NOTED WITH RESTRICTION OF RANGE OF FORAMINAL COMPRESSION TEST WAS POSITIVE.

LUMBOSACRAL SPINE:

MILD PARASPINAL MULTIPLE AREAS OF TENDERNESS ALONG THE LUMBAR SPINE. ESPECIALLY AT THE L 3-5 LEVEL(S), MORE SO ON THE Rt SIDE WITH PARASPINAL MUSCLE SPASM WAS NOTED WITH RESTRICTED RANGE OF MOTION IN PLANES.

SPECIAL STUDIES:

-NONE TO DATE
-OTHER

NEUROLOGICAL EXAMINATION:

MENTAL STATUS: THE PATIENT'S ABILITY FOR IMMEDIATE RECALL IS GOOD. THE LONG TERM MEMORY IS PRESERVED WITHIN NORMAL LIMITS. SPONTANEOUS SPEECH IS FLUENT. SPOKEN LANGUAGE COMPREHENSION IS INTACT. THE REPETITION AND NAMING ABILITY IS NORMAL. BOTH READING COMPREHENSION AND READING ALOUD ARE NORMAL. HIGHER COGNITIVE FUNCTION IS INTACT AND COMPATIBLE WITH THE PATIENT'S LEVEL OF EDUCATION. (PATIENT'S AFFECT APPEARS LABILE).

OLFACTORY FUNCTION IS INTACT. VISUAL ACUITY IS NORMAL. VISUAL FIELDS WITH CONFRONTATION TESTING IS WITHIN NORMAL LIMITS. OPTHALMOSCOPY OF FUNDI REVEAL BOTH DISC MARGINS SHARP, ARTERIOLES OF NORMAL

(50)

EYE MOVEMENTS ARE NOT IMPAIRED, NO NYSTAGMUS REVEALED. THERE IS NO LIMITATION OF CONJUGATE GAZE. PALPEBRAL FISSURES, RIGHT EQUALS LEFT. PUPIL SIZE AND SHAPE ARE NORMAL, RIGHT EQUALS LEFT, APPROXIMATELY 3MM. PUPIL DIRECT AND CONSENSUAL LIGHT REACTION AS WELL AS TO ACCOMMODATION AND CONVERGENCE IS BRISK. CORNEAL REFLEX IS BRISK BILATERALLY. FACIAL SENSATION IS EQUAL AND INTACT ON BOTH SIDES. FACIAL MOVEMENTS ARE SYMMETRICAL AND FULL. HEARING ACUITY IS NORMAL BILATERALLY (6MM). THE GAG REFLEX IS PRESERVED. SWALLOWING IS NOT IMPAIRED. THERE IS NO DEVIATION OF THE TONGUE AS WELL AS NO FASCICULATION OR ATROPHY OF THE TONGUE MUSCULATURE. MOTOR EXAMINATION REVEALED ~~POSITIVE~~/ NEGATIVE BRAXTON HALL PIKE MANEUVER.

RANGE OF MOTION EXAMINATION REVEALED THAT FLEXION EXTENSION OF THE CERVICAL SPINE WAS 50 DEGREES AND OF LUMBOSACRAL SPINE WAS 60 DEGREES.

STRAIGHT LEG RAISE WAS 40 DEGREES ON RIGHT AND 60 DEGREES ON THE LEFT.

REFLEXES:

DEEP TENDON REFLEXES

BILATERAL
NORMAL
2+

BICEPS 2+
TRICEPS 2+
BRACIORADIALS 2+
PATELLAR 2+
ACHILLES 2+

SENSATION
JOINT POSITION / NORMAL
VIBRATION SENSE / NORMAL
TWO POINT DISCRIMINATION / NORMAL
LIGHT TOUCH / PIN PRICK / ~~NORMAL~~ Diminished Rt C5 2pt Distribution

CEREBELLAR TESTING WAS NORMAL IN FINGER TO NOSE AND HEEL TO SHIN TESTS AS WELL AS IN RAPID ALTERNATING MOVEMENTS. ROMBERG TEST WAS NEGATIVE. GAIT WAS ANTALGIC AND DEMONSTRATED NO ATAXIA. TANDEM GAIT WAS NORMAL. NO NYSTAGMUS AND NO DYSMETRIA WAS NOTED.

OTHERS: THERE IS NO EVIDENCE OF MENINGEAL SIGNS. NO BRUITS OF MAJOR VESSELS ARE FOUND. Temp

DEGREE OF DISABILITY
THE ABOVE PATIENT IS PARTIALLY / (TOTALLY) DISABLED AT THIS TIME.

FINAL IMPRESSION:
-POST CONCUSSION SYNDROME
-POST TRAUMATIC HEADACHE

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-DIZZINESS
-CERVICAL MUSCLE POST TRAUMATIC SPRAIN SYNDROME
-LUMBAR POST TRAUMATIC SPRAIN SYNDROME
-POST TRAUMATIC CERVICAL RADICULOPATHY WITH COMPRESSION OF THE C NERVE ROOT ON THE LEFT / RIGHT SIDE (CLINICAL IMPRESSION)
-POST TRAUMATIC LUMBAR RADICULOPATHY WITH COMPRESSION OF THE L NERVE ROOTS ON THE LEFT / RIGHT SIDE.
-POST TRAUMATIC LUMBAR PAIN SYNDROME
-TRAUMATIC HERNIATION OF THE CERVICAL INTERVERTEBRAL DISC
-TRAUMATIC HERNIATION OF THE LUMBAR INTERVERTEBRAL DISC
-POST TRAUMATIC STRESS DISORDER
-POST TRAUMATIC VERTEBROGENIC ENCEPHALGIA
-CERVICOCRAINAL SYNDROME (CLINICAL IMPRESSION)
-PERIPHERAL NEUROPATHY
-CARPAL TUNNEL SYNDROME
-POST TRAUMATIC VERTIGO
-RULE OUT CERVICAL & LUMBOSACRAL RADICULOPATHY
RULE OUT INTERNAL DERANGEMENT OF LEFT / RIGHT KNEE JOINT
RULE OUT INTERNAL DERANGEMENT OF LEFT / RIGHT SHOULDER JOINT
OTHER _____

RECOMMENDATION:

I RECOMMEND THAT, DUE TO THE PATIENT'S COMPLAINTS, THE FOLLOWING TEST BE PERFORMED:
1-SSEP OF THE UPPER/LOWER EXTREMITIES R/O POST TRAUMATIC RADICULOPATHY VS SUPERIMPOSED SUPRA SEGMENTAL SENSORY.
2-EMG AND NCV OF THE UPPER AND LOWER EXTREMITIES TO CLARIFY THE POSSIBLE POST TRAUMATIC NERVE ROOT COMPRESSION.
3-MRI C.S. L.S TO RULE OUT INJURY, DISCOGENIC INJURY, PATHOLOGY OR DISPLACEMENT.
4-CONTINUE THERAPY AND TREATMENT.
5-PAIN MEDICATION _____.
6-REFRAIN FROM STRENUOUS PHYSICAL ACTIVITIES.
7-OTHER PT 3 Times a Wk x 4 wks.

PROGNOSIS:
GUARDED _____.

CASUAL RELATIONSHIP:

IN MY OPINION WITH A REASONABLE DEGREE OF MEDICAL CERTAINTY, THE INJURIES OF THE ABOVE MENTIONED PATIENT, WAS COMPETENT PROVOCATIVE CAUSE OF THE IMPAIRMENT AND DISABILITY AND IN MY OPINION THERE IS A CAUSAL RELATIONSHIP.

THANK YOU FOR THIS REFERRAL. SINCERELY YOURS,

Redacted Signature

JATINDER S. BAKSHI, M.D.

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APPENDIX III

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.

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 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.