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

May 29, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

John David Cunningham, M.D.
[redacted]

T. Lawrence Tabak, Esq.
Tabak & Stimpfl
190 EAB Plaza East Tower, 15th Floor
Uniondale, New York 11556-0190

David W. Smith, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of John David Cunningham, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-139) 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,

[redacted]

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

JOHN DAVID CUNNINGHAM, M.D.

DETERMINATION
AND
ORDER
BPMC 03 - 139

COPY

STEPHEN W. HORNYAK, M.D. (Chair), **PEGGY MURRAIN, Ed.D.**, and **PAUL F. TWIST, D.O.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, ("**ALJ**") served as the Administrative Officer.

The Department of Health appeared by **DAVID W. SMITH, ESQ.**, Associate Counsel.

Respondent, **JOHN DAVID CUNNINGHAM, M.D.**, appeared personally and was represented by **TABAK & STIMPFL** by **T. LAWRENCE TABAK, ESQ.** of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the evidence presented, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	December 23, 2002
Date of Service of Notice of Hearing and Statement of Charges:	January 6, 2003
Date of Answer to Charges:	January 21, 2003
Pre-Hearing Conferences Held:	January 28, 2003 February 11, 2003
Hearings Held: - (First Hearing day):	February 11, 2003 March 17, 2003
Intra-Hearing Conferences Held:	February 11, 2003 March 17, 2003
Location of Hearings:	Offices of New York State Department of Health 5 Penn Plaza, 6th Floor New York, NY 10001
Witnesses called (in the order they testified) by the Petitioner, Department of Health:	Robert Cordone, M.D.
Witnesses called (in the order they testified) by the Respondent, John David Cunningham, M.D.:	John David Cunningham, M.D. Frank DeLuca, M.D. Danne R. Lorieo, M.D. Richard Steven Nitzberg, M.D.
Department's Summation, Findings of Fact, and Conclusions of Law:	Received April 14, 2003
Respondent's Summation, Findings of Fact, and Conclusions of Law:	Received April 14, 2003
Deliberations Held: (last day of Hearing)	April 30, 2003

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York ["**P.H.L.**"]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**"Petitioner" or "Department"**) pursuant to §230 of the P.H.L.

John David Cunningham, M.D., (**"Respondent"**) is charged with one (1) specification of professional misconduct, as delineated in §6530 of the Education Law of the State of New York (**"Education Law"**). Respondent is charged with professional misconduct by reason of practicing the profession with gross negligence [1]. This Charge and Specification of professional misconduct result from Respondent's treatment of one patient [2].

Respondent denies the factual allegations and the Specification of misconduct contained in the Statement of Charges. A copy of the Statement of Charges (without the Appendix) and a copy of the Answer is attached to this Determination and Order as Appendix 1 and 2 respectively.

FINDINGS OF FACT

The following Findings of Fact were made after a review of all of the evidence presented in this matter. These facts represent the documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding relevant to the Statement of Charges. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The

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[1] Education Law §6530(4) - (see also the First Specification of the Statement of Charges [Department's Exhibit # 1].

[2] The record and this Determination and Order refers to the patient by letter to protect patient privacy. Patient A is identified in the Appendix annexed to the Original Statement of Charges (Department's Exhibit #1).

Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

General Findings

1. Respondent was licensed to practice medicine in New York State on January 4, 1993 by the issuance of license number 191021 by the New York State Education Department (Department's Exhibits # 1 and # 4); (Respondent's Exhibit # A)[3]. Respondent is not currently registered to practice medicine in the State of New York (Department's Exhibit # 4); [T-72].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); (Department's Exhibits # 2 and # 3); [P.H.T-6][4].

3. Respondent attended medical school at the University of Wisconsin and graduated in 1985. He then completed a surgical internship and residency at Temple University in Philadelphia, Pennsylvania. He also spent one year in the research laboratory at Temple University as a Reichle Surgical Laboratory Fellow. Respondent completed his final three years of surgical residency in June of 1991. Dr. Cunningham continued his medical training at Memorial Sloan-Kettering, where he completed a surgical oncology fellowship in June 1993. He then accepted a position at Mt. Sinai Hospital as a full-time staff physician as a general surgeon with a specialty in surgical oncology. In November 1998, Dr. Cunningham moved to New Jersey and joined a private practice with a specialty in surgical oncology (Respondent's Exhibit # B); [T- 74-75].

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[3] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. John David Cunningham (Respondent's Exhibit #).

[4] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

PATIENT A

4. On August 5, 1998 Patient A was admitted to Mount Sinai Hospital to undergo a resection of her rectum for her recurrent rectal carcinoma (Department's Exhibit # 5); [T-19-20, 78].

5. On August 6, 1998 Respondent performed surgery on Patient A. The surgery took over seven hours to complete and the patient lost several hundred cc's of blood (Department's Exhibit # 5); [T-20, 78-79].

6. During the August 6, 1998 surgery, two counts were done, by the nursing team, of the laparotomy pads ("**lap pad**")[5] used. Both counts indicated that one lap pad was missing (Department's Exhibit # 5); (Respondent's Exhibit # E); [T-20-25, 80-82].

7. After each count, Respondent performed a visual and manual search of the operative field but did not find a lap pad within Patient A. After each count, the nurses asked Respondent if he wanted to do an x-ray. Respondent refused both times because he did not believe an x-ray was needed (Respondent's Exhibit # E); [T-79-82, 102-103].

8. Respondent did not make any note in the operative report of Patient A's medical records regarding the manner in which he addressed the missing lap pad nor his visual and manual explorations of Patient A's abdominal cavity . Other than the incident report generated by the nurses, Respondent did not address the missing lap pad in Patient A's medical records (Department's Exhibit # 5); (Respondent's Exhibit # E); [T-26, 59-60, 82, 162-163].

9. Lap pads have a radiopaque strip on the edge plus a metal (or plastic) ring attached, for the purpose of being visible on x-ray (Department's Exhibits # 6 and # 10); [T- 20-23].

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[5] A lap pad is basically a fluffy gauze pads anywhere from ten inches to twelve inches square. Generally, they have a colored string attached to them which is usually radiopaque, and sometimes they have a metal or plastic ring attached to the string. The purpose of the metal or plastic ring and the strip is to make them easier to find and to make them show up on x-ray [T-21] and for an example of a lap pad, see Department's Exhibit # 10.

10. On August 6, 1998 Respondent failed to identify and remove from Patient A a lap pad (with metal ring attached) and failed to cause an x-ray to be taken of Patient A before (or after) the patient left the operating room of Mount Sinai Hospital (Department's Exhibits # 5, 6, 7 and # 9); (Respondent's Exhibits # C, D, D-1, D-2, and # E); [T-25-27, 30-32, 39-41, 47, 61, 62-63, 113].

11. Good medical practice and the minimum standard of care required that Respondent take every available step to find the lap pad before Patient A left the operating room. Every available step includes taking an x-ray. A patient should not leave an operating room with an unplanned foreign object still in her because it is dangerous and can cause serious injury such as a fistula, infection, abscess or death (Respondent's Exhibit # H); [T-27, 31, 153].

CONCLUSIONS OF LAW

The Hearing Committee makes the conclusions, pursuant to the Findings of Fact listed above, by a unanimous vote. The Factual Allegations contained in the December 23, 2002 Statement of Charges are **SUSTAINED**.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by a unanimous vote, concludes that the FIRST SPECIFICATION (GROSS NEGLIGENCE) contained in the Statement of Charges is **SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with one (1) specification alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from the memoranda submitted by the Department, entitled: Definitions of Professional Misconduct under the New York Education Law[6]. During the course of its deliberations on these charges, the Hearing Committee consulted the following instructions from the ALJ:

Gross Negligence on a Particular Occasion

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits you find worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to you as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

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[6] A copy of this Memorandum was made available to both parties at the Pre-Hearing Conference [P.H.T-4-5].

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence The Hearing Committee understood that as the trier of fact we may accept so much of a witness' testimony as is deemed true and disregard what we find and determine to be false.

The facts in this case are not really in dispute. Following extensive abdominal surgery lasting over seven hours, a laparotomy pad was left inside Patient A. Prior to closing the patient, Dr. Cunningham was informed by an operating room nurse that the lap pad count was incorrect (off by one). On two separate occasions, Dr. Cunningham explored the abdomen and pelvis and eviscerated the small bowel from the abdominal cavity. He did not find the missing lap pad. Convinced that the lap pad was not inside the patient, Dr. Cunningham proceeded to close the patient. Respondent did not take an x-ray and refused to take an x-ray when twice asked by the operating room nurses.

The only issue before the Hearing Committee is whether or not it was gross negligence for Dr. Cunningham to not order an x-ray of Patient A.

The Hearing Committee unanimously agree that it was gross negligence for Respondent to fail to cause an x-ray to be taken of Patient A in order to attempt to locate the lap pad, before she was removed from the operating room. The Department's expert and the Respondent's expert agreed that they would have ordered an x-ray. The Department's Board Certified in general surgery expert, Dr. Cordone, was unequivocal "If you can't find a missing object, you have to get an x-ray." [T-26-

27, see also T-30-32, 39-40]. "The whole point of all the counts and of getting the x-ray is to prevent the patient from leaving the operating room with implanted materials they weren't intended to leave with." [T-40, see also T-40-41, 47, 61, 62-63]. Respondent's Board Certified in general surgery expert, Dr. Lorieo, indicated "In my own practice, I probably would have gotten an x-ray ..." and " If the nurses report that something is missing, the first thing we do is re-examine the abdomen; irrigate, suck everything out, go through visually and manually. And if we still can't find it and they still haven't found it in pathology or underneath the table then we would get an x-ray." [T-155; see also T-157, 159-160].

Where patient care is at issue being 100% sure (as indicated by Respondent) is not good enough where an extra (easily available) step is available. Nursing Articles notwithstanding, a minimally prudent physician would have taken an x-ray. Failure to do so, especially when it was easily available, was more than just gross negligence, it showed a reckless indifference to good patient care. Respondent was offered two opportunities to take an x-ray and denied both. This was not a judgment call. No hospital protocol was necessary or relevant. No hindsight is necessary. Respondent's failure to take the x-ray under the facts presented was an egregious act and a significant deviation from acceptable medical standards. Respondent's inaction (failure to take an x-ray) created a substantial risk of injury and potentially grave consequences to Patient A. We need not and do not determine whether Patient A's death was a cause of Respondent's gross negligence.

One of the most disturbing aspects of Respondent's failure was that this matter was completely preventable by the taking of an x-ray. Even if the x-ray failed to show the lap pad, at least Respondent would not have been faulted because he would have done everything he could have done for the safety of the patient. Unfortunately Respondent did not give Patient A the care that she deserved or that she should have received.

In accordance with the above understanding the Hearing Committee unanimously determined that the allegations and the charges contained in the Statement of Charges were established by a preponderance of the evidence.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented during the Hearing including the parties' summations and proposed conclusion and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee unanimously determines that Respondent's license to practice medicine in New York should be SUSPENDED for ONE year, that the SUSPENSION should be STAYED and that Respondent should be placed on PROBATION for a period of TWO (2) YEARS starting when he returns to practice medicine in New York State and including the standard terms of probation (attached as Appendix 3).

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a., including: (1) Censure and Reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service; (10) Probation and (11) Dismissal in the interest of justice.

The Hearing Committee's choices of penalties were somewhat limited because Respondent does not currently practice medicine in New York State. The Hearing Committee does not believe that Censure and Reprimand is a sufficient penalty to address Respondent's gross negligence. This is especially true given Respondent's lack of insight and remorse. Respondent gave no indication to the Hearing Committee that he believed he was wrong in failing to take an x-ray. Respondent was slow to admit to and agree that in the future, given similar circumstances, he would be sure to

have an x-ray taken. Respondent continued his adamant belief that his visual and manual searches were satisfactory, as good as an x-ray would have been, and constituted 100% of his responsibility to his patient.

On the other extreme, the Hearing Committee agreed that revocation of Respondent's license would be too harsh a penalty for this one egregious act. Respondent appears to have the qualifications and abilities to be a productive asset to the medical community and the public. Although Respondent had an opportunity to prevent the occurrence of a mishap and failed to avail himself of that opportunity thereby putting his patient in harm's way, we believe that this Hearing process together with the above penalty will alert Respondent to his responsibilities. The message to Respondent and other practitioners is to take every precaution available which will benefit their patients.

The Hearing Committee considered an actual suspension with a defined time period but rejected that option for two reasons. First the Department did not ask for actual suspension of Respondent's license. Second, and more importantly, Respondent presently does not practice medicine in New York and may never do so in the future. Therefore we believe that an actual suspension, as opposed to a stayed suspension, would serve no additional purpose. We also believe that a stayed suspension should send a sufficient message that Respondent's conduct was serious and needs to be addressed appropriately wherever he practices. We do not believe any of the other available sanctions to be appropriate or relevant to Respondent's misconduct.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read the transcripts and have considered all of the admitted evidence of this proceeding.

ORDER

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

1. The FIRST SPECIFICATION contained in the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED**; and

2. The Factual Allegations contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and

3. Respondent's license to practice medicine in New York is **SUSPENDED FOR ONE YEAR, AND THAT SUSPENSION IS STAYED**; and

4. Respondent will be placed on **PROBATION FOR A PERIOD OF TWO (2) YEARS** effective on his return to practice medicine in New York State; and

5. The terms of probation, attached as Appendix 3, shall be followed by Respondent; and

6. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: New York
27 May, 2003

[redacted]

STEPHEN W. HORNYAK, M.D. (Chair)
PEGGY MURRAIN, Ed.D.
PAUL F. TWIST, D.O.

TO:

John David Cunningham, M.D.
[redacted]

T. Lawrence Tabak, Esq.
Tabak & & Stimpfl
190 EAB Plaza East Tower,15th floor
Uniondale NY,11556-0190

David W. Smith, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

APPENDIX 1

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

IN THE MATTER

OF

JOHN DAVID CUNNINGHAM, M.D.

STATEMENT

OF

CHARGES

JOHN DAVID CUNNINGHAM, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 4, 1993, by the issuance of license number 191021 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Following an abdomino-perineal resection on Patient A on or about August 6, 1998 at Mount Sinai Hospital, New York, New York, Respondent failed to identify and remove from the patient a laparotomy pad and ring, and failed to cause an x-ray to be taken of Patient A before such patient left the operating room.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

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

1. Paragraph A.

DATED: December 23, 2002
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

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

IN THE MATTER

OF

JOHN DAVID CUNNINGHAM, M.D.

ANSWER TO STATEMENT OF CHARGES

Respondent 1-28-03 A In Evid

Respondent, John David Cunningham, M.D., by his attorneys, Tabak & Stimpfl, answers the Statement of Charges of the Bureau of Professional Medical Conduct as follows:

1. Admits that Respondent was authorized to practice medicine in New York State on or about January 4, 1993, by the issuance of License # 191021 by the New York State Education Department.

2. Denies each and every allegation contained in paragraph "A" of the Statement of Charges, except admits performing surgery on Patient A on or about August 6, 1998, and when advised of a discrepancy with regard to the count of laparotomy pads, Respondent took adequate and reasonable measures and met accepted medical standards to determine the presence of any retained laparotomy pad.

3. Denies Specification of Charges designated "First".

WHEREFORE, Respondent prays for a Determination and Order dismissing the Statement of Charges and Specification in their entirety.

Dated: January 21, 2003
Uniondale, New York

TABAK & STIMPFL
Attorneys for Respondent

By: [redacted]
T. Lawrence Tabak
190 EAB Plaza
East Tower – 15th Floor
Uniondale, New York 11556-0190
(516) 663-5357

TO: Honorable Tyrone Butler
Director, Bureau of Adjudication
New York State Department of Health
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180

David W. Smith, Esq., Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
5 Penn Plaza, 6th Floor
New York, NY 10001

APPENDIX 3

Terms of Probation for JOHN DAVID CUNNINGHAM, M.D.

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. 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 on Respondent's return to practice in New York State.

5. 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.

6. 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.

7. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. On 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.