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

November 20, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Uma Sundaram, M.D.

Redacted Address

Sanford R. Shapiro, Esq.
Boylan, Brown, Code, Vigor, et al
2400 Chase Square
Rochester, New York 14604

Michael A. Hiser, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Uma Sundaram, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-261) 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 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

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh

Enclosure

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

IN THE MATTER

OF

UMA SUNDARAM, M.D.

COPY

DETERMINATION

AND

ORDER

BPMC NO. 06-261

A Notice of Hearing and a Statement of Charges, each dated March 10, 2006 was served upon the Respondent, **UMA SUNDARAM, M.D. CHARLES J. VACANTI, M.D.,** Chairperson, **RICHARD LEE, M.D. and MARY PATRICIA MEAGHER, R.N.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The Department of Health ("the Department") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **MICHAEL A. HISER, ESQ.**, of Counsel. The Respondent appeared and was represented by **SANFORD R. SHAPIRO, 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

Answer Filed	April 11, 2006
Prehearing Conference	April 7, 2006
Witnesses for Petitioner-Department	John B. Rodgers, Jr., M.D. Wife of Patient K Outi Goldstein, R.N. George Y. Kunze, M.D. Mary Jo LaVilla, R.N. Rachel O. Trombley, R.N. Kevin Robillard, M.D. Nicole Ciufo, R.N. Tarek Qutob, M.D.
Witnesses for Respondent	George Triadafilopoulos, M.D. Uma Sundaram, M.D. (Respondent)
Hearing Dates	April 20-21, May 11-12, June 15-16, July 13-14
Deliberation Date (final day of hearing)	September 14, 2006

STATEMENT OF CASE

The State Board for Professional Misconduct 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 [hereinafter P.H.L.]).

This matter was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Uma Sundaram, M.D. ("Respondent") was charged with thirty specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). These charges included allegations that Respondent committed professional misconduct by having practiced the profession of medicine with gross negligence on a particular occasion,

with gross incompetence, with negligence and with incompetence on more than one occasion, with moral unfitness and fraudulently. Respondent was further charged with failing to maintain a record for each patient which accurately reflected the care and treatment of the patient, failing to exercise appropriate supervision over persons who are authorized to practice only under his supervision and ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient. A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix II.

LEGAL ISSUES

A number of legal matters were addressed by the Administrative Law Judge (ALJ) during the course of the proceedings. Motions made by Respondent to dismiss the charges against him and to disqualify a member of the Hearing Committee were denied at the prehearing conference. The admission of materials found in medical journals and treatises was denied as constituting cumulative evidence to testimony from medical experts for both parties that was offered to establish accepted standards of practice. Respondent's motion to adjourn the scheduled June 15 hearing date due to the unavailability of witnesses was denied and Respondent was directed to appear and testify on that date. A number of exhibits offered into evidence by both parties were not received for reasons set forth in the hearing record.

During and subsequent to the proceeding, the Department withdrew certain charges, including Factual Allegations B.1., C. and C.1., D.4., F.2., and Specification of Charges 9.

Respondent was permitted to amend his Answer (Exhibit A) to add the following to Paragraph B: "Respondent later testified that it was unclear as to when the perforation occurred or who caused it."

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

GENERAL FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State on September 17, 2001 by the issuance of license number 222794 by the New York State Education Department. (Ex. 2)

2. Chronic hepatitis C is known to cause cirrhosis of the liver and eventually liver failure. Cirrhosis occurs when chronic inflammation of the liver causes so much scarring in the liver that normal architecture of the liver is disrupted. (T. 42)

3. A diagnosis of cirrhosis is made on the basis of clinical information and imaging studies such as a CT scan. The standard method to diagnose cirrhosis is a liver biopsy, in which case the pathologist can grade the inflammation and scarring in the liver so the physician knows where the patient is in the evolution of the process. This information is useful to determine whether to treat a patient with hepatitis C and to establish suitability for a possible transplant. (T. 43)

4. An ERCP is an Endoscopic Retrograde Cannulation of the common bile duct and/or pancreatic duct. This procedure is performed with an instrument similar to that used in an upper gastrointestinal endoscopy, except that the instrument has a side viewing lens which enables the physician to view the area of the ampulla of Vater. (T. 31)

5. In the performance of an ERCP, the instrument is passed down the esophagus through the stomach and out into the duodenum. The ampulla is identified, and at that point a catheter is inserted through a channel in the scope and positioned to enable it to be introduced into the ampulla and advanced retrograde. The objective is to cannulate either the common bile duct or the pancreatic duct. Contrast material, liquid radio- opaque dye, is then injected retrograde to fill these ducts. (T. 31-32)

6. An ERCP can be a technically difficult procedure requiring rather heavy sedation which increases patient risk. There is also a risk of perforation of the gastrointestinal tract and a risk of inducing infection in a retrograde fashion. When the common bile duct is filled, bacteria in the area can be transported back into the liver and cause micro abscesses and even gram negative

septicemia. Also, when the pancreatic duct is filled there is a 2% risk of developing post procedure pancreatitis. (T. 36, 52-53)

7. ERCPs are performed to treat conditions in the biliary system which refers to the ducts that drain the liver and gallbladder and includes the common bile duct. The information that is relevant for a physician in making a decision whether to perform an ERCP is to have some indication of an abnormality of the biliary tree as shown by either an abnormal imaging study or by unexplained liver tests that point to obstructive jaundice. (T. 37-38, 86)

8. An ERCP is performed to treat abnormalities that have been detected and is an effective procedure for the treating of stones found in the common bile duct. (T. 38)

9. Abnormal liver function test results are not indications to perform an ERCP because enough new information would not ordinarily be obtained to justify the procedure. An ERCP is not performed to confirm a diagnosis of cirrhosis and does not assess the degree of inflammation or scarring in a patient's liver. A biopsy will indicate the amount of scarring in the liver. (T. 45, 47, 88, 1316)

FINDINGS OF FACT RELATED TO PATIENT A

10. Respondent saw Patient A, a 53 year old female, on March 6, 2002, to evaluate her for chronic hepatitis C. Patient A had advanced liver disease. Respondent's assessment and recommendation as documented in the patient's chart was that "because of her abnormal liver

function tests, we will perform an ERCP to delineate her biliary tree and confirm the diagnosis of cirrhosis." (Ex. 4, pp. 36-37)

11. The patient underwent an ERCP on June 11, 2002. The pre-procedure indication for the ERCP was "Hepatitis C, rule out cirrhosis." Confirmation of a diagnosis of cirrhosis in the patient was necessary, particularly if the patient was proceeding to liver transplant or if there was consideration of treating the patient for Hepatitis C. (Ex. 3, p. 47; T. 46)

12. The impression of the ERCP as performed was "normal, common bile duct, pancreatic duct and common hepatic duct with slight pruning of the intra hepatic duct.". (Ex. 3, p. 47; T. 47)

FINDINGS OF FACT RELATED TO PATIENT B

13. Respondent evaluated Patient B, a 29 year old male, on June 13, 2002 and determined the patient to have chronic active hepatitis. A follow up evaluation was conducted by Respondent on September 13, 2002. Respondent documented a need to evaluate Patient B for cirrhosis and recommended performance of an ERCP to assess if scarring in the liver was present and a liver biopsy to assess the degree of inflammation. (Ex. 6, pp. 61-62, 64-65)

14. Respondent performed an ERCP on the patient on September 18, 2002. The pre-procedure indication as recorded in the procedure note was "Hepatitis B". The procedure was technically difficult to perform. The common bile duct could not be cannulated, i.e. radio opaque

contrast could not be maneuvered into the common bile duct. The pancreatic duct was cannulated and was found to be normal. (Ex. 6, p. 116)

15. The indications for performance of the ERCP were not reflected in Patient B's medical record. Respondent did not record an intention to assess the patient's extra-hepatic (outside the liver) biliary system for "sludge or stones" in the June, 2002 evaluation report. He also did not document whether he was looking for ductal system scarring, which an ERCP could evaluate, or parenchymal scarring, which an ERCP would not evaluate. (Ex. 6, pp. 61-62, 64-65, 116; T.1367-1368, 1370)

16. Results of liver function tests performed on Patient B did not clearly demonstrate the presence of stones or sludge indicating duct obstruction. (Ex.6, pp.107-8, T. 1364)

FINDINGS OF FACT RELATED TO PATIENT C

17. Respondent evaluated Patient C, a 54 year old female, on November 5, 2002 and documented an impression of hepatitis C and cirrhosis. The patient had a history of alcohol abuse and was on a waiting list for a liver transplant. (Ex. 8, pp. 23-24, 33, 35-36)

18. Respondent ordered an ERCP to assess hepatobiliary obstruction, which is an obstruction of bile outflow in either the liver or biliary tree. The clinical sign a patient has such an obstruction is usually a total and direct or conjugated bilirubin level and an alkaline phospatase level two and one half times the upper limits of normal. (Ex. 8, p.23, T. 104)

19. The laboratory studies indicated a total bilirubin which was normal. The alkaline phosphotase was 127, with an upper limit of normal 126. There was no clear and consistent evidence of hepato-biliary obstruction in this patient. (Ex. 9, p. 38; T. 1306)

20. A liver biopsy was performed on November 13, 2002; the results of the liver biopsy indicated that the patient had chronic hepatitis with moderate activity and advanced cirrhosis. The liver biopsy results did not provide any additional basis to perform an ERCP. (Ex. 9, p. 55; T. 107-108)

21. An ERCP was performed by Respondent on this patient on December 17, 2002. The indications for the procedure were "cirrhosis from Hepatitis C infection, rule out biliary obstruction.". The findings of the ERCP indicate "no evidence of biliary obstruction." The ERCP as documented by Respondent did not provide any information relevant to the treatment of the patient. (Ex. 9, p. 13; T. 108)

FINDINGS RELATED TO PATIENT D

22. Respondent performed an evaluation of Patient D, a 59 year old female patient, on January 9, 2003. She had a history of alcohol abuse and a recent significant weight loss. (Ex. 11, pp.6-7)

23. Patient D had blood drawn on that day; laboratory results for her Hepatitis C profile indicated the presence of an Hepatitis C antibody, which suggested present or past infection with

Hepatitis C. The patient had some abnormal lab results including alkaline phosphotase being elevated. The patient's abnormal lab studies were consistent with a patient who had cirrhosis. The patient's ALT test result was normal and not consistent with an obstructive process. (Ex. 11, pp.22-24; T. 1279-1280)

24. Respondent documented that the patient would be scheduled for an ERCP, "because of her elevated total bilirubin." (Ex. 11, p 7)

25. The patient's total bilirubin was noted to be elevated at 2.9 as reflected by the results of the January 9, 2003 laboratory tests. This total bilirubin is decreased from a level of 3.7 as documented in a laboratory report of November 4, 2002. (Ex. 10, p. 29, Ex. 11, p. 16)

26. Liver function tests refers to the studies of bilirubin, alkaline phosphotase and other enzymes related to the liver. Abnormal liver function tests would be an adequate indication to perform an ERCP on Patient D if there were no other explanation and a CT scan was abnormal. Patient D's history of alcohol abuse and possible hepatitis C provided other explanations for the abnormal test results. (T. 131)

27. An ERCP was performed on Patient D on February 26, 2003. The pre-procedure indication documented by Respondent was "abnormal liver function test and weight loss." The result of the ERCP indicated that the patient had a "normal cholangiogram and pancreatogram," as it related to the indications of abnormal liver function test and weight loss. (Ex. 11, p. 29)

28. Respondent did not document in Patient D's medical record that he was considering the presence of a papillary tumor in his performance of an ERCP on this patient. (Ex. 11, pp. 6-7)

FINDINGS RELATED TO PATIENT E

29. Respondent evaluated Patient E, a 48 year old male, on November 21, 2002. The patient had previously been diagnosed as having hepatitis C and a CT scan of his liver, performed in November 2001, revealed cirrhotic morphology. (Ex. 12, pp. 23-24, Ex. 13, pp. 83-84)

30. Respondent documented a plan to "proceed with an ERCP to look for evidence of cirrhosis in his biliary tract and possible causes." (Ex. 12, p. 24)

31. Respondent performed an ERCP on this patient on February 27, 2003. The pre-procedure indication documented in Respondent's procedure note was "presence of abnormal liver function test, to rule out the presence of biliary strictures or common bile duct stones." The impressions from the ERCP were that the patient had a "normal pancreatogram", and "unable to canulate the common bile duct". (Ex. 13, p. 72)

CONCLUSIONS OF LAW RELATED TO PATIENTS A THROUGH E

These five cases involved similar allegations and the Committee considered them as a group. The Committee distinguished the charges of Respondent's having ordered, performed and/or supervised the performance of an ERCP without medical indication from the charges of

his having failed to document adequate medical indication. The five patients clearly had varying stages of liver disease. Each was under consideration as a candidate for liver transplantation. While the Committee concluded the results of the ERCPs were of minimal or limited value in the overall care and treatment of the patients, they were found to provide some useful information in evaluating the patient's candidacy for a transplant.

Respondent's testimony made it unclear as to his independence in scheduling the procedures; he created an impression that surgeons with the transplant program had that responsibility and that he was a mere technician in following their directives. The Committee was dissatisfied with an arrangement in which Respondent appeared to have no input in determining the appropriateness of performing certain endoscopic procedures.

The Committee members unanimously agreed that Respondent's documentation of the indications for the ERCPs was significantly inadequate. While a review of a patient's entire chart may have revealed the necessity of the procedures, the procedure notes did not make the indications clear. There was agreement with the testimony of both experts that an ERCP is not performed to confirm a diagnosis of cirrhosis. Respondent consistently omitted clinical indications for performance of these procedures. While he testified as to a variety of conditions he intended to rule out by conducting the ERCP, these possibilities were not recorded. Another practitioner examining the procedure notes would be unable to comprehend Respondent's treatment plans.

The Committee sustained Factual Allegations A.1. through A.5. based on Respondent's failure to adequately document medical indications for performance of the ERCPs. These failures were considered to be evidence of practice of the profession of medicine with negligence on more than one occasion and the failure to maintain a record for each patient which accurately

reflected the care and treatment of the patient. There was a consensus that the results of the procedures, although of minimal value, provided some limited amount of information helpful in evaluating the appropriateness of a liver transplant. Accordingly, performance of the procedures was not determined to constitute the ordering of excessive tests, treatment, or use of treatment facilities not warranted by the patient's condition.

FINDINGS RELATED TO PATIENT F

32. Respondent was recorded as the attending physician for the performance of a screening colonoscopy on Patient F, an 82 year old female, on August 21, 2002. Dr. Qutob, a third-year GI fellow, was listed as the assistant to Respondent in the procedure note. (Ex. 16, p. 26)

33. Respondent was not present when the procedure was started. Dr. Qutob initiated it by inserting the colonoscope. He encountered difficulty passing it because of a stricture, or narrowing, in the patient's colon. Dr. Qutob then requested the GI unit nurse to inform the Respondent of the situation. When told that the fellow had encountered difficulty in moving the scope, Respondent directed that Dr. Qutob switch scopes and use a pediatric colonoscope instead of an adult scope. At that time, he did not come to the room where the procedure was taking place. (T. 595-597)

34. Dr. Qutob withdrew the adult colonoscope, switched to the smaller scope and began the insertion again. At some point thereafter, it became apparent that the colon had been perforated. The nurse left the room again and advised Respondent of the situation; he then came into the

room where the procedure was being performed. Respondent took over the scope and confirmed that he thought a perforation had occurred. He then withdrew the pediatric scope. (T. 597-599)

CONCLUSIONS RELATED TO PATIENT F

The allegation of misconduct related to Patient F is not that Respondent was not present at the start of the colonoscopy or that misconduct occurred because of the perforation of the colon. It is not disputed that a third year GI fellow could begin the procedure or that a perforation was a known risk in undertaking the colonoscopy. Respondent's alleged misconduct was his failure to be present when it became apparent that the fellow was having difficulty inserting the adult scope.

The Committee believed that it was a judgement call as to whether Respondent was required to be present once he was informed of the difficulty in advancing the adult colonoscope. That problem was a common enough event that a third year fellow could reasonably be expected to address it. Dr. Triadafilopoulos distinguished that situation from Respondent's obligation to be present had a perforation been recognized by the fellow. In that event, the supervising physician would be expected to take over and address the complication. The record indicated that the perforation was observed at some point following insertion of the pediatric scope; at such time Respondent was present. The Committee agreed with this approach and did not sustain Factual Allegation B.2. The operative note (Ex. 16, p. 26) was viewed as adequately reporting the relevant aspects of the procedure; Factual Allegation B.3. was not sustained.

FINDINGS RELATED TO PATIENT H

35. Respondent provided care and treatment to Patient H, a 53 year old male, in June, 2002, including performances of an EGD on June 12, 2002, a colonoscopy on June 13, 2002 and enteroscopies on June 14 and July 17, 2002. (Ex. 22, pp. 44, 48-49, 52-53)

36. An EGD (esophagastroduodenoscopy) is performed to address a gastrointestinal bleed, or complaints of debilitating upper GI pain, iron deficiency, and anemia. Conscious sedation is routinely used for this procedure. (T. 187-188)

37. The EGD (also known as an "upper GI") is a procedure performed by a gastroenterologist using a fiber optics bendable scope and with a camera in the distal end projecting images on television monitors. An enteroscopy is essentially the same procedure, except sometimes a different scope is used that provides additional viewing into the small intestine. Enteroscopy is performed in cases of gastrointestinal bleeders where endoscopy and colonoscopy have been negative and there is reason to believe the patient is still bleeding. (T. 189-190)

38. An upper GI endoscopy was performed on June 12, 2002 on this patient. The indications for this procedure were to "rule out upper GI bleed. Patient presents with lowered hematocrit and bright red blood per rectum." The patient had a hematocrit level of 12, a dangerously low reading. The findings were documented as being an "unremarkable EGD." There was no bleeding and no ulcers were found. The impression was that the patient had a lower GI bleed or source. Mild gastritis was also biopsied. (Ex. 22, pp. 52-53; T. 192)

39. The recommendation following the EGD was to perform a colonoscopy. The patient underwent a colonoscopy on June 13, 2002. The finding that was significant relative to bleeding was a finding of "severe diverticulosis". There was no evidence of active bleeding. The recommendation following the colonoscopy was that an enteroscopy be performed for the patient to "rule out any small bowel pathology, i.e. arteriovenous malformations". (Ex. 21, p. 18)

40. An enteroscopy was performed on Patient H on June 14, 2002. The pre-procedure indication was "history of gastrointestinal bleeding, rule out the presence of small bowel pathology." The procedure note was electronically signed and finalized by Respondent and described a finding of "three deep ulcers" with surrounding edema in the antrum of the stomach. The ulcers were not seen two days previously when the EGD was performed. (Ex. 21, pp.16-17)

41. It is possible for ulcers to be observed two days following performance of an EGD which made no findings of the presence of ulcers. An ulcer could have formed over a two day period or could have been missed in the earlier procedure. Another possibility was that the biopsy of the gastritis conducted during the EGD created small ulcers that were observed during the subsequent endoscopy. (T.1335, 1341-1343)

42. There was no documentation in the medical record of an explanation as to why there was a difference in the findings between the June 12 and June 14, 2002 procedures. (Ex. 21-22; T. 231)

43. A followup enteroscopy was performed on July 17, 2002. Respondent was the attending physician for that procedure. The followup enteroscopy was performed less than 5 weeks after the enteroscopy of June 14. The indication for the repeat enteroscopy was "GI bleed, antral ulcer, no obvious source"; the source of the GI bleed remained unexplained. (Ex. 21, pp. 5-6; T. 199)

44. The findings from the enteroscopy of July 17, 2002, were that the patient had multiple antral ulcers, severe gastritis, and a normal enteroscopy up to 120cm. (Ex. 21, pp. 5-6)

CONCLUSIONS RELATED TO PATIENT H

The Committee members determined that Respondent adequately supervised and/or performed the procedures of June 12 and 14, 2002 and did not sustain Factual Allegation D.1. The testimony of Dr. Triadafilopoulos was relied on for this conclusion. He offered several credible reasons for ulcers to have been seen two days after none were reported.

The failure of Respondent to address the inconsistent findings of the two procedures by documenting a possible explanation was clearly improper. The inconsistency was significant and needed to be discussed in the chart. The Committee sustained Factual Allegation D.2. and Specifications that this failure was evidence of Respondent's practice of the profession of medicine with negligence and incompetence. By a 2-1 majority vote, the Committee determined Respondent's omission was not so egregious as to constitute gross negligence.

Whether it was proper to conduct the July 17, 2002 repeat enteroscopy about one month after the earlier procedure was considered as another example of a judgement call that was not

considered to be improper. The source of the patient's internal bleeding was not firmly established and further exploration was justified. Factual Allegation D.3. was not sustained.

FINDINGS RELATED TO PATIENT I

45. Patient I, a 39 year old female with diabetes mellitus, was admitted to the Emergency Department on June 11, 2002 with chief complaints of abdominal pain and diarrhea and was examined by Respondent. He recommended performance of both an EGD and an enteroscopy. (Ex. 25, pp. 5-6, 27-31, 49)

46. On June 18, 2002, the patient underwent the EGD. The pre-procedure indication was recorded as "history of abdominal pain. Rule out peptic ulcer disease." Respondent was documented in the procedure note as being "present' and having "supervised the procedure throughout." The esophagus was evaluated and biopsies taken; the stomach was inspected and mild gastritis was found. No ulcers were observed. An antrum biopsy was taken. The first and second part of the duodenum was inspected and appeared normal (Ex. 25, pp. 44-45)

47. An enteroscopy was performed the following day, June 19, 2002. The preprocedure indication was noted as "chronic diarrhea". Findings indicated that the scope was advanced into the duodenum, and then into the mid jejunum. The jejunum mucosa was normal appearing. The stomach was documented as "still" showing an antral ulcer. The antral ulcer was not shown in the EGD done the day before, notwithstanding the fact that the same organs were evaluated. (Ex. 25, pp. 44, 46)

48. Respondent "signed and finalized" the EGD procedure note on June 21, 2002 at 12:46; he also "signed & finalized" the contrary enteroscopy procedure note on June 21, 2002 at 12:46. Although he had before him inconsistent notes at the same time, Respondent did not explain the inconsistency in Patient I's medical record. Respondent failed to accurately document his evaluation and treatment of Patient I, insofar as he documented that the patient had "no ulcer" on June 18, and the patient "still" had an ulcer on June 19, 2002. (Ex. 25)

49. An enteroscopy is part of the standard workup for a patient with diarrhea that is related to malabsorption. (T.1383-1384)

50. Patient I's primary care physician followed up with a letter to Respondent dated July 12, 2002 in which he indicated that he had received faxed reports of the procedures from Respondent, including the enteroscopy and the EGD. He admitted being confused because the push enteroscopy stated that the patient "still showed the antral ulcer" whereas the EGD reported that the patient merely had "mild gastritis." The primary care physician further indicated that he had called the Respondent's office on numerous occasions and as of July 12, 2002 had not been contacted. (Ex. 23, p. 3)

51. Respondent sent a letter to his chief of medicine in July, 2002 which purported to respond to the letter from Patient I's primary care physician. In Respondent's letter, he concluded that the reference in the procedure note of June 19, 2002 that the patient had a "antral ulcer" was not correct in that there was no antral ulcer and what was observed during the enteroscopy was in fact merely the mislabeled site of the antral biopsy taken the day before. (T. 1075-1079; Ex. U)

52. It is possible to misconstrue a biopsy site as an antral ulcer. Such a site is an anomaly that would normally be commented on during the performance of a procedure. (T. 1390)

CONCLUSIONS RELATED TO PATIENT I

The fact that the procedure notes from the EGD and enteroscopy were inconsistent did not mean that Respondent inadequately performed and/or supervised one or both of those procedures. The inconsistent findings needed to be explained in the chart; the failure to address those findings was considered an egregious deviation from accepted standards of medical practice. The Committee accepted Dr. Triadafilopoulos' opinion that it is possible to misconstrue a biopsy site as an antral ulcer; he stated that the different findings should have been commented on in the medical record. Factual Allegation E.1. was not sustained; Factual Allegation E.2. was sustained and determined to constitute the practice of medicine with negligence, gross negligence and incompetence.

The June 19, 2002 enteroscopy was considered to be indicated by Patient I's complaint of diarrhea, the cause of which had not been established. The Committee considered an enteroscopy to be an acceptable method of evaluating the patient's condition. Factual Allegation E.3. was not sustained.

Respondent's failure to properly document the differing findings of the EGD and enteroscopy understandably caused confusion in the mind of the patient's primary care physician as to whether an antral ulcer was actually present. The Committee sustained Factual Allegation E.4. as it related to a failure to adequately document treatment for the patient.

FINDINGS RELATED TO PATIENT J

53. Respondent provided medical care to Patient J, a 78 year old male, at various times from on or about June 2002 to approximately November 2002. The patient had complaints of diarrhea, dehydration and a 12-15 pound weight loss. Respondent was the attending physician for the performance of an EGD on July 9, 2002 and an enteroscopy on July 16, 2002. (Ex. 28, 29)

54. The patient had an upper GI small bowel series performed on June 14, 2002. The impression was that the remainder of the small bowel was unremarkable; a mild dilatation of a loop of the small bowel in the upper midabdomen was noted. (Ex. 28, p. 15)

55. Respondent performed an enteroscopy on Patient J on July 16, 2002. The indication for the procedure was diarrhea. During the enteroscopy procedure, the jejunum was examined and biopsies were taken of both the jejunum and the duodenum. The pathology report from the biopsies revealed that there were no "significant histological abnormalities". (Ex. 29, pp. 21, 27)

56. Respondent electronically signed a letter to the patient's primary care physician on September 12, 2002. The examination of the patient is documented that it "it reveals a woman who appears clinically well and in no acute distress." (Ex. 28, pp. 35-36)

CONCLUSIONS RELATED TO PATIENT J

The Committee believed that the patient's complaints of weight loss, diarrhea and dehydration were indications for performance of the enteroscopy on July 16, 2002. The fact that an upper GI series was performed only a few weeks earlier without a determination of the cause of the diarrhea and that a single dialated loop of the small bowel was observed supported Respondent's performance of the enteroscopy. However, Factual Allegation F.1. was sustained in that the medical indications for performance of the procedure were inadequately documented in the chart. It was necessary to search the record for clues as to Respondent's actions in order to piece together an explanation for the plan of treatment. In addition, the obvious error of his September 12, 2002 letter to Patient J's primary care physician, which referred to a female patient, reflected a carelessness in efforts to maintain an accurate record that concerned the Committee members. This carelessness was observed in a number of patient records. The inadequate and inaccurate record for this patient was determined to be evidence of the practice of the profession with both negligence and incompetence.

FINDINGS RELATED TO PATIENT K

57. Respondent provided medical care to Patient K, a 46 year old male, at various times beginning in 2002. The patient was had a history of chronic Hepatitis C, chronic pancreatitis and cirrhosis in stage 4. In September, 2002, the patient had been hospitalized due to dehydration, abdominal pain, vomiting and diarrhea. (Ex. 30, p. 16)

58. Patient K underwent an endoscopy in March, 2002; the pathology report indicated that the findings were consistent with celiac disease. Prominent villous flattening and patchy villous blunting were noted. These findings supported a diagnosis of non-tropical sprue, a malabsorption disorder associated with an inability to to digest foods containing gluten. (Ex. 30, pp.16, 96-97; T. 299, 1289-1290)

59. A gluten free diet was recommended for Patient K by his previous gastroenterologist in June, 2002. (Ex. 30, p.19)

60. Respondent evaluated Patient K on October 17, 2002. At the conclusion of the evaluation, the patient was scheduled for multiple procedures, including an enteroscopy with multiple biopsies to assess for Celiac sprue. (Ex. 30, p. 16)

61. The patient and his wife discussed the Respondent's evaluation and recommendations with his primary care physician and decided to not undergo the procedures scheduled by Respondent. (T. 364-365)

CONCLUSIONS RELATED TO PATIENT K

By 2-1 majority vote, the Committee determined to not sustain factual allegation G.1. The majority felt that it was a matter of judgement as to whether Respondent believed Patient K's assertion that he maintained a gluten free diet. If the patient was honestly reporting compliance with the restricted diet and the complaints of vomiting and diarrhea continued, Respondent had a

basis for ordering additional tests. The fact that the patient did not follow Respondent's recommendation and undergo further testing was also a consideration for the majority members to not sustain the Factual Allegation. The member voting in the minority concluded that Respondent should not have believed that the patient was maintaining a gluten free diet based on the patient's history and therefore should not have ordered an additional enteroscopy.

FINDINGS RELATED TO PATIENT L

62. Respondent provided medical care to Patient L, a 49 year old male, at various times beginning in 2002 and was the attending physician for the performance of an enteroscopy on December 3, 2002. (Ex. 34)

63. The patient underwent a liver transplant on April 11, 2002, due to his end stage liver disease related to chronic Hepatitis C and hemochromatosis. Respondent evaluated the patient on October 3, 2002. Based on that evaluation, Respondent ordered the patient to have a liver biopsy, EGD, ERCP, and colonoscopy. (Ex. 34, pp. 10, 141)

64. The patient underwent an upper endoscopy on October 9, 2002. Respondent took biopsies of the antrum of the stomach, but failed to take biopsies of the duodenum. (Ex. 34, pp. 84, 137-138)

65. Respondent performed a follow up evaluation of this patient on November 7, 2002 and ordered an enteroscopy for the patient to "rule out malabsorption." (Ex. 34, pp.7-8)

66. Respondent performed an enteroscopy on this patient on December 3, 2002. The pre-procedure indication was malabsorption and anemia. The findings of the enteroscopy were that the patient had "three plus esophageal varices." These had been noted on the earlier EGD performed in October, 2002. Antral gastritis and portal gastropathy were also found. Biopsies were obtained of the jejunum; the biopsy report indicated that there was "normal villous architecture with no increase in intra-epithelial lymphocytes." There was nothing indicated on the pathology report that appeared to be abnormal. (Ex. 34, pp. 71, 132)

CONCLUSIONS RELATED TO PATIENT L

By a 2-1 majority vote, it was determined to sustain Factual Allegation H.1. as related to the performance of the December 3, 2002 enteroscopy without medical indication. Respondent should have taken a biopsy of the duodenum during the October, 2002 endoscopy to address concerns of malabsorption without subjecting Patient L to an additional procedure. The member voting in the minority believed that additional indications were present in the patient to justify performance of the enteroscopy. The Committee unanimously determined to sustain Factual Allegation H.1. as it related to Respondent's failure to adequately document medical indications for the procedure. The brief statement "rule out malabsorption" was considered to not provide adequate information to indicate performance of the enteroscopy. The treatment by Respondent of Patient L was determined to constitute practice of the profession with negligence and with incompetence. By majority vote, Specification 29 was also sustained, in relation to the performance of excessive tests and/or treatment not warranted by the condition of the patient.

FINDINGS RELATED TO THE INTERVIEWS OF RESPONDENT

67. Respondent was employed at the Strong Memorial Hospital and the University of Rochester as a Professor of Medicine and as Chief of the Digestive Diseases Unit from approximately October, 2001 through April, 2004. (Ex. O; T. 705-706, 741-743)

68. Respondent was interviewed by representatives of the New York Department of Health, Office of Professional Medical Conduct [OPMC] on three occasions; April 27, April 29 and September 27, 2004. On each occasion, Respondent was asked questions about, and gave information relating to, the performance of EGDs, enteroscopies, colonoscopies, and ERCPs on his patients while he was employed at the Strong Memorial Hospital and the University of Rochester. Specific areas of inquiry addressed Respondent's presence during those procedures and the supervision he provided to the gastroenterology fellows. (T. 541-547)

69. Respondent stated that in 90% of the cases he was in the procedure room from the beginning of insertion through the end of withdrawal. He stated that there were times where he might not be there for that entire period, but for the vast majority, 90% of the time, he was present. (T. 546-549)

70. During the interviews, Respondent stated that when he gave instruction to "get started" with either the EGD or the colonoscopy or the enteroscopy, he intended that the fellows only have the consent form signed and then have sedation administered. (T. 549)

71. The common understanding of the nursing staff of the unit and the gastroenterology fellows was that the instruction to "get started" meant that the consent should be obtained, sedation should be given and the patient should be intubated with the scope, meaning inserting the scope into the patient and proceeding to the end point of the particular procedure. (T.408, 460, 514-515, 580-581)

CONCLUSIONS RELATED TO THE INTERVIEWS OF RESPONDENT

The allegations in Paragraph I of the Statement of Charges created confusion during the course of this proceeding and significantly extended its duration. The Committee, by majority vote, determined to sustain Factual Allegations I.1. and I.2. in that two members concluded that Respondent's statement that he was present for a significant period of time in 90% of the cases when the gastroenterology fellows performed EGDs, enteroscopies or colonoscopies was false, and further concluded that his statement that instructions to the fellows to "get started" did not include the actual insertion of the scope was also false. This determination was based on the consistent testimony offered by a number of former fellows and nursing staff from the unit. The contention by Respondent that he meant to say at the interviews that his answers were in reference only to his most difficult cases and that he was frequently not present during the simpler cases was rejected by a majority of the Committee. The minority voting member believed that the Department did not meet its burden of proof in that no documentary evidence was produced to refute Respondent's statements. For reasons addressed below, the Committee unanimously determined that the statements did not constitute practice of the profession fraudulently or conduct evidencing moral unfitness; Specifications 19 and 20 were not sustained.

The Department did not allege that Respondent committed professional misconduct by failing to be present when the fellows performed the procedures in question. In fact, had Respondent stated that he *never* was present during those procedures, it would appear he would not have faced any charge of misconduct. Thus, the charges in Paragraph I related only to the belief that Respondent was not truthful during the interviews.

The Committee considered the testimony of Dr. Triadafilopoulos, who indicated that there are no national standards for establishing when an attending physician must be present when a gastroenterology fellow performs an endoscopic procedure. In March, 2003, Respondent issued a memorandum directing that no insertion should be started unless the attending was physically present in the room to supervise the entire procedure. There was agreement that Respondent complied with that policy until he left the employ of the hospital. It would appear Strong Memorial had no issue with Respondent's compliance with whatever policy was in place for the approximately 11/2 years of his employment prior to March, 2003.

The essential basis of Paragraph I is that Respondent made false statements, with an intent to deceive, during the course of his interviews. The fact that he provided false information about matters he was not required to comply with mitigates the impact of his statements. The Department's investigation was not impeded as a result of the misrepresentations. It was also noted that separate allegations of a failure to exercise appropriate supervision were made in three of the eleven cases addressed during the course of this proceeding. The Committee was able to evaluate the evidence and make a determination on those specific charges. The allegations concerning the statements made at the interviews added little to the overall charges when there was no underlying policy violated regardless of whether or not Respondent was physically present in the procedure room.

The Committee members believed it would have been more appropriate to have charged that Respondent engaged in the fraudulent practice of medicine as a result of the alleged ordering and performance of unwarranted and excessive tests and treatments. If, in fact, the procedures were unnecessary it could certainly be argued that recommendation of those procedures was a false representation intended to mislead the patients. The Committee considered the absence of allegations of fraud in relation to the treatment of specific patients inconsistent with the allegations of Paragraph I where the Respondent gave false information about matters with which he was not required to comply.

Finally, the Committee recommends that allegations of fraud based on events occurring during the OPMC interview process be issued judiciously. The intent of the interview is to resolve disputes in advance of a formal adjudicatory hearing. Respondents should not be made to feel reluctant to participate in the process. In this matter, the Committee felt fully capable, based on the allegations concerning his treatment of eleven patients, to evaluate Respondent's competence and character without inclusion of the issue of immaterial statements made during the interview, even if those statements were false.

DISCUSSION

Respondent was charged with multiple specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. The

memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law", sets forth suggested definitions for negligence, gross negligence, incompetence, gross incompetence and fraudulent practice.

The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding. (Id.).

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, 546 N.Y.S. 2d 1005 (1989). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion (Rho, supra at 322). No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad", articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence, if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient. Post v. State of New York Department of Health, 245 A.D. 2d 985, 986, 667 N.Y.S. 2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her

conduct, Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752, 634 N.Y.S. 2d 856 (3d Dept. 1995).

Incompetence is the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with incompetence "on more than one occasion". "On more than one occasion" carries the same meaning it does in relation to negligence on more than one occasion as set forth above.

Gross Incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences, Post, Supra, at 986.

The **fraudulent practice of medicine** is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine and with the intent to deceive. Choudry v. Sobol ("Choudry"), 170 A.D. 2d 893, 566 N.Y.S. 2d 723 (3d Dept. 1991) citing Brestin v. Commissioner of Education ("Brestin") 116 A.D. 2d 357, 501 N.Y.S. 2d 923 (3d Dept. 1986) (dentistry). To sustain a charge that a licensee has engaged in the fraudulent practice of medicine, the Committee must find that 1)a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, 2) the licensee knew the representation was false, and 3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D. 2d 315, 266 N.Y.S. 2d 39 (3d Dept. 1966), aff'd. 19 N.Y. 2d 679, 278 N.Y.S. 2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent, Choudry, supra at

894 citing Brestin. Fraudulent intent may be inferred from evidence that the licensee was aware of the true state of facts at the time false responses were given. Saldanha v. DeBuono, 256 A.D.2d 935, 681 N.Y.S. 2d 874 (3d Dept. 1998).

The Committee closely reviewed the testimony of all witnesses to determine their credibility and establish the weight to be given to their statements. Dr. Rodgers was considered to be very credible and the Committee believed he was objective and open-minded in his review of Respondent's care of the patients. His criticisms were not of Respondent's ability as a technician. The fact that Dr. Rodgers had not taken the Boards to become certified in Gastroenterology, but instead was "grandfathered" in and that he also had no experience in performing ERCPs did not detract from the consideration given to his opinions as to whether sufficient indications were present to justify performance of the procedures. His teaching and clinical experience was extensive and provided a valid basis for such opinions. It was also noted that he more than once provided exculpatory information that resulted in the withdrawal of certain allegations. The Committee assigned great weight to his testimony.

Dr. Triadafilopoulos made a strong impression with the Committee and he was found to be both well qualified and very articulate. His opinions were concise and clear and considered very credible. However, it was observed that Dr. Triadafilopoulos admitted to having discussed the care of the patients with Respondent before testifying and, in addition, that he relied on notes prepared by the Respondent when offering his testimony. Those facts reduced his objectivity and the weight afforded to his answers by the Committee. On several occasions he made assumptions as to the condition of a patient or Respondent's thought process so as to give Respondent the benefit of any doubt concerning the medical care rendered. By having to "read between the lines" so often, the inadequacy of Respondent's documentation became more obvious.

Respondent's testimony was frequently self-serving and the Committee believed he often failed to directly respond to the questions that he was asked. His responses were verbose and the Committee members felt that he frequently lectured them while actually failing to answer questions. He was considered to be an adequate technician, but substandard in his communication with his peers. His testimony concerning the statements he offered at his interviews was found to not be credible.

Three nurses from the GI unit and three former fellows from the Gastroenterology Department also testified, primarily to address the allegations in Paragraph I. The personal animosities and disagreements between unit staff became obvious and it was clear that Respondent was not held in high regard by the nurses and fellows. Their testimony was therefore not without bias; however, they consistently described Respondent's practices on the unit concerning his presence during the procedures and instructions to the fellows. The Committee relied on the uniformity of those descriptions in making its determination concerning the allegations in Paragraph I.

The majority of the Factual Allegations sustained by the Committee related to Respondent's failure to adequately and appropriately document patient conditions and indications for invasive procedures. The Committee afforded Respondent some latitude in determining the manner in which he would treat patients, many of whom were suffering from serious liver disease. However, Respondent's documentation failures should not be minimized as mere record keeping errors. The Committee considered Respondent to be seriously deficient in his communication with peers and other medical providers. This is of greater concern when Respondent acted as a consulting specialist in which case he would be expected to fully advise

others as to recommended courses of treatment. In a number of cases, Respondent failed to do so by not clearly explaining his justification for ordering enteroscopies, EGDs and ERCPs. A one word indication was an inadequate explanation. The failures to address contradictions in procedure notes, as seen in the records of Patients H and I, were examples of Respondent's sloppy and cavalier approach to acceptable record keeping and confused the patients' primary care physicians. Proper standards of medical documentation were sacrificed in the face of the heavy volumn of GI procedures performed while Respondent was Chief of the Digestive Diseases Unit. The Committee concluded that such a trade-off was not acceptable.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's New York medical license should be suspended for two years and that he be placed on probation in accordance with the Terms of Probation, as set forth in Appendix I, during the period of suspension. The period of licensure suspension and probation shall be tolled for such period as Respondent does not engage in the active practice of medicine in New York. This determination was 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 to a specified area or type of practice;
(4) Revocation of the license; (5) Annulment of the license or registration;
(6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training;
(9) Performance of public service, and (10) Probation.

The Committee determined that Respondent's actions and failures to act were significant enough so as to require that his medical license be suspended for an actual period of time. Respondent's testimony demonstrated that he possesses an adequate level of knowledge as to the actual requirements for acceptable record keeping; a continuing medical education course in that subject was found to be unnecessary.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following Factual Allegations of professional misconduct are **SUSTAINED:**

    a. A.1.-A.5.;

    b. D.2.;

    c. E.2.;

    d. F.1.;

    e. H.1.

    All other Factual Allegations are **NOT SUSTAINED** and are **DISMISSED**; and

2. The following Specifications of Charges are **SUSTAINED:**

    a. Fifth;

    b. Seventeenth;

    c. Eighteenth;

    d. Twenty-ninth;

    e. Thirtieth.

    All other Specifications of Charges are **NOT SUSTAINED** and are **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be hereby **SUSPENDED** for a period of two years, and;

4. Respondent shall be placed on **PROBATION** during the period of the suspension of his license, and he shall comply with all terms of probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order.

5. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law §12-a.

DATED: Troy, New York

18 November, **2006**

Redacted Signature

CHARLES J. VACANTI, M.D., Chairperson,

RICHARD V. LEE, M.D.

MARY PATRICIA MEAGHER, R.N.

TO:

Michael A. Hiser, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
2509 Corning Tower
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Sanford R. Shapiro, Esq.
Boylan, Brown, Code, Vigdor & Wilson, LLP
2400 Chase Square
Rochester, New York 14604

Uma Sundaram, M.D.

Redacted Address

APPENDIX I

Terms of Probation

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

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, 4th Floor, 433 River Street, 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. Prior to the commencement of a medical practice in New York State, Respondent shall submit written proof to the Director of the OPMC at the address indicated above that she has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department.

4. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide periodic written 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.

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

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

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients.

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.

APPENDIX II

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

IN THE MATTER

OF

UMA SUNDARAM, M.D.

STATEMENT

OF

CHARGES

UMA SUNDARAM, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 17, 2001, by the issuance of license number 222794 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated each of the Patients A, B, C, D, and E [patients are identified only in the attached Appendix] at the Strong Memorial Hospital, 601 Elmwood Avenue, Rochester, New York 14642 [hereafter, "Strong Memorial Hospital"] and the University of Rochester during the time he was Chief of the Digestive Diseases Clinic on the various dates listed below. Respondent ordered, performed, and/or supervised the performance of endoscopic retrograde cholangiopancreatography ["ERCP"] procedures for each of the patients. Respondent's care of the patients individually failed to meet accepted standards of medical care in that:

1. Respondent, on or about 6/11/02, ordered, performed, and/or supervised the performance of an ERCP on Patient A, a 53 year old female, without adequate medical indication, and/or without documenting adequate medical indication.

2. Respondent, on or about 9/18/02, ordered, performed, and/or supervised the performance of an ERCP on Patient B, a 29 year old male, without adequate medical indication, and/or without documenting adequate medical indication.

3. Respondent, on or about 12/17/02, ordered, performed, and/or supervised the performance of an ERCP on Patient C, a 52 year old female, without adequate medical indication, and/or without

documenting adequate medical indication.

4. Respondent, on or about 2/26/03, ordered, performed, and/or supervised the performance of an ERCP on Patient D, a 59 year old female, without adequate medical indication, and/or without documenting adequate medical indication.

5. Respondent, on or about 2/27/03, ordered, performed, and/or supervised the performance of an ERCP on Patient E, a 48 year old male, without adequate medical indication, and/or without documenting adequate medical indication.

B. Respondent provided medical care to Patient F, an 82 year old female, at various times beginning in 2002, at Strong Memorial Hospital. Respondent was the attending physician for the performance of, among other procedures, a colonoscopy that was attempted on 8/21/02. Respondent's care of Patient F failed to meet accepted standards of medical care in that:

1. Respondent, on or about 8/21/02, ordered the performance of a screening colonoscopy on Patient F without adequate medical indication, and/or without documenting adequate medical indication.

2. Respondent, on or about 8/21/02, directed a Gastroenterology Fellow at Strong Memorial Hospital, Dr. "Q", to sedate the patient, then make several attempts to insert a colonoscope into the patient, even though the Respondent was not physically present to supervise the Fellow during insertions of the colonoscope. During scope insertion, the patient's bowel was perforated. Respondent failed to properly supervise the performance of the colonoscopy.

3. Respondent failed to accurately document the events that occurred during the colonoscopy of 8/21/02, including the sequence of events that lead to the perforation of the patient's bowel.

C. Respondent provided medical care to Patient G, a male patient 52 years old, at various times in 2002 at the Strong Memorial Hospital. Respondent was the attending physician for the performance of an enteroscopy on Patient G on or about 9/10/02. Respondent's care of Patient G failed to meet accepted standards of medical care, in that:

1. Respondent, on or about 9/10/02, ordered, performed, and/or supervised the performance of an enteroscopy on Patient G without adequate medical indication, and/or without documenting adequate medical indication.

D. Respondent provided medical care to Patient H, a 53 year old male, at various times beginning in 2002, at the Strong Memorial Hospital. Respondent was the attending physician for the performance of, among others, an esophagastroduodenoscopy ["EGD"] on 6/12/02, a colonoscopy on 6/13/02, an enteroscopy on 6/14/02, a repeat enteroscopy on 7/17/02, and a repeat colonoscopy on 6/4/03. Respondent's care of Patient H failed to meet accepted standards of medical care in that:

1. Respondent, on or about 6/12/02, performed and/or supervised the performance of an EGD, and the Respondent documented that "no ulcers" were found in the patient's stomach. Respondent also performed and/or supervised the performance of an enteroscopy two days later, on 6/14/02, which Respondent documented as finding "3 deep ulcers with surrounding edema" in the patient's stomach. Respondent failed to adequately perform one or both of these procedures, and/or failed to be present for and properly supervise one or both of the procedures.

2. Respondent failed to adequately document an evaluation of the inconsistent findings from the EGD of 6/12/02 and the enteroscopy of 6/14/02.

3. Respondent, on or about 7/17/02, ordered, performed, and/or supervised the performance of a repeat enteroscopy, without adequate medical indication, and/or without documenting adequate medical indication.

4. Respondent, on or about 6/4/03, ordered, performed, and/or supervised the performance of a repeat colonoscopy, without adequate medical indication, and/or without documenting adequate medical indication.

w/d 4/21/06

E. Respondent provided medical care to Patient I, a 40 year old female, at various times beginning in 2002, at the Strong Memorial Hospital. Respondent was the attending physician for the performance of, among

others, an EGD on 6/18/02 and an enteroscopy on 6/19/02. Respondent's care of Patient I failed to meet accepted standards of medical care in that:

1. Respondent, on or about 6/18/02, performed and/or supervised the performance of an EGD on Patient I, and Respondent documented the procedure found "no ulcers". The next day, on 6/19/02, Respondent performed and/or supervised the performance of an enteroscopy, and Respondent documented that the "stomach still showed antral ulcer". Respondent failed to adequately perform one or both of these procedures, and/or failed to be present for and properly supervise one or both of the procedures.

2. Respondent failed to adequately document an evaluation of the inconsistent findings from the EGD of 6/18/02 and the enteroscopy of 6/19/02.

3. Respondent, on or about 6/19/02, ordered, performed and/or supervised the performance of an enteroscopy, without adequate medical indication, and/or without documenting adequate medical indication.

4. Respondent, despite documenting that the patient had an antral stomach ulcer as shown in the enteroscopy performed on 6/19/02, failed to adequately treat or order the treatment of the patient for this problem, and/or document that he had provided or ordered such treatment.

F. Respondent provided medical care to Patient J, a 78 year old male, at various times from on or about June 2002 to approximately November 2002. Respondent was the attending physician for the performance of, among others, an EGD on 7/9/02, an enteroscopy on 7/16/02, and a colonoscopy on 7/31/02. Respondent's care of Patient J failed to meet accepted standards of medical care, in that:

1. Respondent, on or about 7/16/02, ordered, performed and/or supervised the performance of an enteroscopy without adequate medical indication and/or without documenting adequate medical indication.

2. Respondent, on or about 7/31/02, ordered, performed and/or supervised the performance of a colonoscopy without adequate medical indication, and/or without documenting adequate medical indication.

G. Respondent provided medical care to Patient K, a 46 year old male, at various times beginning in 2002, at the Strong Memorial Hospital. Respondent was the attending physician for an evaluation of the patient on or about October 17, 2002, following which the Respondent ordered the performance of an EGD, a colonoscopy, an enteroscopy, and an ERCP. Respondent's care of Patient K failed to meet accepted standards of medical care in that:

1. Respondent, on or about October 17, 2002, ordered the performance of an enteroscopy without adequate medical indication, and/or without documenting adequate medical indication.

H. Respondent provided medical care to Patient L, a 49 year old male, at various times beginning in 2002, at the Strong Memorial Hospital. Respondent was the attending physician for the performance of, among others, an EGD on 10/9/02, a colonoscopy on 11/6/02, and an enteroscopy on 12/3/02. Respondent's care of Patient L failed to meet accepted standards of medical care in that:

1. Respondent, on or about 12/3/02, ordered, performed and/or supervised the performance of an enteroscopy without adequate medical indication, and/or without documenting adequate medical indication.

I. Respondent was interviewed by representatives of the New York Department of Health, Office of Professional Medical Conduct [OPMC] on or about May 11, 2004, and on or about September 27, 2004. On both occasions, Respondent was asked questions about, and gave information relating to, the performance of EGDs, enteroscopies, colonoscopies, and ERCPs on his patients, beginning September 2001, while Respondent was employed at the Strong Memorial Hospital, and the University of Rochester

as Chief of the Digestive Diseases Unit. Respondent was also asked about the nature of the supervision he provided to Gastroenterology Fellows training in the Digestive Diseases Unit, especially while they were performing the procedures outlined above.

1. Respondent, when interviewed by OPMC representatives, on both occasions intentionally and falsely told them that for 90% of his cases where EGDs, Enteroscopies, or colonoscopies were performed by Gastroenterology Fellows, he was in the procedure room from insertion of the endoscope through withdrawal of the endoscope.

   In fact, for the majority of such cases, at least between November 2001 and March or April 2003, Respondent was absent from the procedure room for a significant portion of the time from insertion of the endoscope through withdrawal of the endoscope.

2. Respondent, when he was interviewed by OPMC representatives on September 27, 2004, intentionally and falsely told them that Respondent's instructions to the Gastroenterology Fellows to "get started" with EGD, colonoscopy, and enteroscopy procedure[s], or words to that effect, required only that they have the patient sign the consent form, and then administer sedation.

   In fact, at least between November 2001 and March or April 2003, Respondent's express instructions to the Fellows were to begin insertion of the endoscopes even if Respondent was not present, and to proceed with insertion of the scope to the furthest anatomical end point of the procedure.

SPECIFICATION OF CHARGES

FIRST THOUGH EIGHTH 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 facts of the following:

1. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5.
2. The facts as set forth in paragraphs B and B.1, and/or B and B.2.
3. The facts as set forth in paragraphs C and C.1.
4. The facts as set forth in paragraphs D and D.1, D and D.2, D and D.3, and/or D and D.4.
5. The facts as set forth in paragraphs E and E.1, E and E.2, E and E.3, and/or E and E.4.
6. The facts as set forth in paragraphs F and F.1, and/or F and F.2.
7. The facts as set forth in paragraphs G and G.1.
8. The facts as set forth in paragraphs H and H.1.

NINTH THROUGH SIXTEENTH 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 facts of the following:

w/D 9. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5.

10. The facts as set forth in paragraphs B and B.1, and/or B and B.2.
11. The facts as set forth in paragraphs C and C.1.
12. The facts as set forth in paragraphs D and D.1, D and D.2, D and D.3, and/or D and D.4.

13. The facts as set forth in paragraphs E and E.1, E and E.2, E and E.3, and/or E and E.4.

14. The facts as set forth in paragraphs F and F.1, and/or F and F.2.

15. The facts as set forth in paragraphs G and G.1.

16. The facts as set forth in paragraphs H and H.1.

SEVENTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

17. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, C and C.1, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, G and G.1, and/or H and H.1.

EIGHTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

18. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3,

A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, C and C.1, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, G and G.1, and/or H and H.1.

NINETEENTH SPECIFICATION

FRAUD

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

19. The facts as set forth in paragraphs I and I.1 and/or I and I.2.

TWENTIETH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine, as alleged in the facts of the following:

20. The facts as set forth in paragraphs I and I.1 and/or I and I.2.

TWENTY-FIRST SPECIFICATION

FAILING TO EXERCISE APPROPRIATE SUPERVISION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(33) by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, as alleged in the facts of the following:

21. The facts in paragraphs B and B.1, D and D.1, and/or E and E.1.

TWENTY-SECOND THROUGH TWENTY-NINTH SPECIFICATIONS

ORDERING UNWARRANTED AND EXCESSIVE TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

22. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5.
23. The facts as set forth in paragraphs B and B.1.
24. The facts as set forth in paragraphs C and C.1.
25. The facts as set forth in paragraphs D and D.3, and/or D and D.4.
26. The facts as set forth in paragraphs E and E.3.
27. The facts as set forth in paragraphs F and F.1, and/or F and F.2.
28. The facts as set forth in paragraphs G and G.1.
29. The facts as set forth in paragraphs H and H.1.

THIRTIETH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

30. The facts as set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.3, C and C.1, D and D.2, D and D.3, D and D.4, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, G and G.1, and/or H and H.1.

DATED: March 10, 2006
Albany, New York

Redacted Signature

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