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STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Richard F. Daines, M.D.
Commissioner

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Executive Deputy Commissioner

December 14, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Khalid Parwez, M.D.
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Bureau of Professional Medical Conduct
Corning Tower – Room 2517
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Albany, New York 12237

RE: In the Matter of Khalid Parwez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-217) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

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

COPY

IN THE MATTER OF KHALID PARWEZ, M.D.	DETERMINATION AND ORDER

BPMC NO. 09-217

A Notice of Hearing and Statement of Charges, both dated February 27, 2009, were served upon **KHALID PARWEZ, M.D.**, Respondent. **JERRY WAISMAN, M.D.**, Chairperson, **ELEANOR KANE, M.D.**, and **MARY ANN CRESANTI, N.P.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by **JEFFREY J. CONKLIN, ESQ.**, of Counsel. The Respondent appeared by Carter, Conboy, Case, Blackmore, Maloney & Laird, P.C., **JOHN T. MALONEY, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	March 2, 2009
Answer Filed:	March 20, 2009
Pre-Hearing Conference:	March 24, 2009
Hearing Dates:	April 2 and 3, 2009 May 7, 8, 11, 14 and 15, 2009 June 12 and 23, 2009 July 17, 2009
Witnesses for Petitioner:	Joel Cooper, M.D. Catherine Sickler, L.P.N. Linda Tripoli
Witnesses for Respondent:	Khalid Parwez, M.D. Robert Dropkin, M.D.
Receipt of Submissions:	September 30, 2009
Deliberation Held:	October 19, 2009

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 [hereinafter "P.H.L."]).

This case 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. On April 1, 2009, Petitioner's motion to collaterally estop Respondent from denying the allegations regarding Patient F was denied. On

April 9, 2009, Petitioner's motion to amend the Statement of Charges was granted. Khalid Parwez, M.D. ("Respondent") is charged with ninety-four specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). The charges relate to Respondent's medical care of seven patients. The charges include allegations of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, and performing professional services that were not authorized by the patient. A copy of the Notice of Hearing and Amended Statement of Charges is attached to this Determination and Order as Appendix I.

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. Other 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, the Hearing Committee

hereby makes the following findings of fact:

1. Khalid Parwez, M.D., the Respondent, was authorized to practice medicine in New York State on September 17, 1976, by the issuance of license number 128379 by the New York State Education Department (Ex. 3).

Patient A

2. Patient A had a myocardial infarction in 1998. She underwent cardiac catheterizations in June 1998, July 1998 and April 2000 (Ex. 4B, p. 25, 99; Ex. G, p. 13).

3. Patient A was admitted to the hospital for chest pain in July 1998, April 1999, February 2000, November 2000, July 2001, September 2001 and October 2001 (Ex. 4B, p. 99).

4. Patient A had a mild mitral valve prolapse (Ex. 4B, p. 34, 98; Ex. G, p. 16).

5. Patient A was prescribed nitroglycerine, Cardizem, Imdur, and aspirin for her cardiac related problems and chest pain (Ex. 4B, p. 94; T. 33).

6. Respondent provided medical care to Patient A beginning in December 2001, after Patient A had been referred for a bleeding fibroid uterus and a complex mass on her left ovary (Ex. 4A, p. 2; T. 1036).

7. On January 30, 2002, Respondent performed a hysteroscopy, laparoscopy, and cystoscopy on Patient A (Ex. 4B, p. 29-30).

8. On March 13, 2002, Respondent performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy and cystoscopy on Patient A (Ex. 4B, p. 79-80).

9. The standard of care required Respondent to obtain a cardiac medical clearance for Patient A by a qualified cardiologist or internist before performing the January 30 and March 13, 2002 surgeries (T. 33-37, 58).

10. Respondent did not obtain a cardiac clearance by a qualified cardiologist or internist prior to the January 30 and March 13, 2002 surgeries (Ex. 4A, 4B).

11. Respondent's failure to obtain the required cardiac clearance posed life-threatening risks to Patient A, including risk of stroke, severe arrhythmia, myocardial infarction and congestive heart failure (T. 36-39, 62). (2-1)

12. Based on Patient A's cardiac history, Respondent's failure to obtain an appropriate cardiac clearance was a serious deviation from the standard of care (T. 38). (2-1)

13. Respondent's performance of a cystoscopy on Patient A in January and March 2002 was appropriate and within the standard of care (T. 1,532-1536). (2-1)

Patient B

14. Respondent first provided medical care to Patient B on February 11, 1997 (Ex. 5A, p. 2).

15. In 2001, Respondent provided obstetrical care to Patient B who had an expected delivery date of April 7, 2001 by ultrasound (Ex. 5A, p. 19).

16. On February 6, 2001, Patient B's blood pressure was 128/84 (Ex. 5A, p. 27).

17. On February 27, 2001, Patient B's blood pressure was initially 142/105, but was 126/90 on retest (Ex. 5A, p. 27).

18. Patient B's blood pressures recorded in the office after 31 weeks gestation required observation, but did not require medication (T. 1,351).

19. Having experienced abdominal pain and vomiting, Patient B was admitted to the hospital on March 4, 2001 for observation. A nonstress test was performed on the patient. She had no complaints of headache, vision changes, dizziness or edema. Upon discharge the following day, she was advised to rest at home and instructed to return to Respondent's office the day after (Ex. 5B, p. 30-42).

20. Patient B was readmitted to the hospital on March 7, 2001 at 7:15 p.m., and bloods were drawn (Ex. 5B, p. 60).

21. The lab results were returned at 9:55 p.m., and Respondent was in to see the patient at 10:00 p.m. (Ex. 5B, p. 60).

22. Respondent's diagnosis was HELLP syndrome, and he gave orders to stabilize the patient and administer magnesium sulfate, but the orders were not recorded on the physician's order sheet (T. 823,

Ex 5B, p. 150).

23. At March 7, 2001 at 11:45 p.m., Respondent ordered Apresoline (Ex. 5B, p. 150).

24. On March 8, 2001 at 12:10 a.m., Respondent ordered a repeat HEELP panel. By 1:00 a.m., Patient B's blood pressure had been stabilized to 125/79 (Ex. 5B, p. 61). At 1:30 a.m., the patient was awake briefly with no complaints and a blood pressure of 130/87 (Ex. 5B, p. 61).

25. On March 8, 2001 at 2:00 a.m., Respondent received the results from the repeat HELLP panel, and he ordered the patient prepared for a C-section (Ex. 5B, p. 61).

26. This was the appropriate time to order a C-section (T. 1,368). (2-1)

27. HELLP syndrome is a very rare condition which cannot be prevented by giving medications (T. 1,353-1.354, 1,361). The treatment is delivery (T. 1,354).

28. Respondent performed the C-section at 3:08 a.m. (Ex. 5B, p. 62).

Patient C

29. Respondent provided obstetrical care to Patient C who was admitted to the hospital for a scheduled induction on February 9, 2004. At the time, she weighed 342 lbs (Ex. 10A, p. 2, 30).

30. Respondent's plan was to start Cervidil and then Pitocin

(T. 909).

31. The Cervidil was removed at approximately 9:00 p.m. because of difficulty monitoring the patient. Patient C was not in labor, and she was permitted to rest overnight (Ex. 10A, p. 62; T. 912-913).

32. It is difficult to insert a fetal monitor unless a patient is 1 to 2 cm dilated (T. 1,429).

33. On March 10, 2004 at 8:10 a.m. when Respondent saw Patient C, she was only one fingertip dilated. Patient C wanted to continue with the Pitocin (Ex. 10A, p. 58).

34. Respondent could not have inserted an internal lead if Patient C was only one fingertip dilated (T. 248).

35. Respondent returned again at 9:10 a.m., and gave instructions to continue Pitocin when a good tracing was obtained (T. 917).

36. Respondent was in the operating room from 9:10 to 9:40 a.m. When he returned to Patient C, there was abnormal fetal heart tracing. He did an evaluation at that time, and the patient was 3 cm dilated (T. 917-918).

37. The fetal monitoring strips show intervals when it was difficult to assess the fetal heart rate and reassuring intervals. There was enough reassurance in terms of variability and absence of recurrent late decelerations to allow the labor to continue (T. 1,443-1,445).

38. Performing a C-section also held risks in particular due to Patient C's obesity (T. 1,439).

39. The monitoring strips showed no repetitive late decelerations until Respondent decided to perform a C-section (T. 1,474).

40. At 12:05 p.m., Respondent decided to perform a C-section (Ex. 10A, p. 63).

41. Induction of anesthesia was started at 12:29 p.m. and completed at 12:38 p.m., at which time surgery was started (Ex 10A, p. 31).

42. A physician has to balance the risks to the mother and to the baby when deciding whether to perform a C-section. Respondent performance of the C-section on Patient A was timely (T. 1,439-1,440, 1,474). (2-1)

Patient D

43. Patient D's due date passed, and she was admitted to the hospital on August 25, 2003 for induction (6A, p. 28-29).

44. Respondent inserted Cervidil at 5:00 p.m. (Ex. 6A, p. 28).

45. Just prior to 6:00 p.m., the fetal monitoring strips displayed mild late decelerations (Ex. 6B, p. 34; T. 1,478).

46. The monitoring strips then demonstrate a couple of mild late decelerations with excellent variability (Ex. 6B, p. 36-37; T. 1,479).

47. Respondent was paged at 6:46 p.m., and he arrived at 7:00 p.m. (Ex. 6A, p. 29).

48. After a discussion with Patient D, Respondent decided to perform a C-section (Ex. 6A, p. 32; T. 1,001).

49. The Cervidil was removed, and the patient was given oxygen, medication and IV hydration. She was also turned on her side (Ex. 6A, p. 32).

50. From the time of Respondent's decision to perform a C-section at 7:10 p.m. until the incision at 8::03 p.m., the monitoring strip was reassuring. The strip showed good variability and no recurrent late decelerations (T. 1,481).

51. Respondent ordered and performed the C-section on Patient D in a timely fashion (T. 1,482-1,483). (2-1)

Patient E

52. Respondent first provided medical care to Patient E on September 19, 2001 when she presented with vaginal bleeding (Ex. 7A, p. 2).

53. Patient E was admitted to the hospital on October 4, 2001 for a dilation and curettage laparoscopy (Ex. 7B, p. 61).

54. The laparoscopy was converted to a laparotomy because an adnexal mass was adherent to the bowel, pelvic sidewall and omentum. Respondent performed a cystoscopy at the end of the procedure (Ex. 7B, p. 61; T. 1,169 - 1,170, 1,592).

55. The surgery was very difficult, and an inadvertent injury to the bowel occurred (T. 1,170).

56. Respondent appropriately decided to perform a cystoscopy (T. 1.592). (2-1)

Patient F

57. Patient F was admitted to the hospital on November 23, 1998 for a hysteroscopy, dilation and curettage, and laparoscopy (Ex. 9D, p. 31).

58.. Anesthesia was started at 8:35 a.m. (Ex. 9B, p. 30).

59. Respondent performed the hysteroscopy and commenced the laparoscopy which included inserting a Veress needle and later a trocar into the abdominal cavity (Ex. 9D, p. 47-48).

60. During the laparoscopic procedure, a surgical complication occurred which caused an oblique transection of the aorta on its right side and an oblique transection of the vena cava on the left side (Ex. 9D, p. 49).

61. At 9:05 a.m., Patient F's blood pressure was 148/86, and her pulse was 115 (Ex. 9D, p. 43).

62. Patient F had no blood pressure and a thready pulse at 9:13 a.m, and a code blue was called (Ex. 9D, p. 50).

63. The standard of care required Respondent to make a timely diagnosis of the cause of a patient's hypotension (T. 557).

64. The standard of care required Respondent to commence an

exploratory laparotomy promptly and take appropriate action to stem the bleeding (T. 547, 557).

65. The risk of harm to Patient F was life-threatening. The risks included profound shock, blood loss, pituitary failure, kidney failure, peripheral vascular problems secondary to the torn aorta, stenosis of the abdominal aorta and vena cava, bowel problems, injuries to the retroperitoneal space and retroperitoneal hematoma (558-559).

66. Patient F lost approximately 3,500 cc's of blood during the surgery, an amount equal to her total blood volume (Ex. 9D; T. 545).

67. Respondent failed to perform a timely laparotomy. At 9:50 a.m., another surgeon entered the operating room and performed a laparotomy promptly to stop the patient's bleeding (Ex. 9D, p. 49; T. 530).

Patient G

68. Respondent provided gynecological care for Patient G from February 1998 through July 2002 (Ex. 8A, 8B).

69. On July 11, 2002, Respondent performed a total abdominal hysterectomy on Patient G (Ex. 8B, p. 90-91).

70. Based upon intraoperative findings, Respondent performed a cystoscopy which was indicated and necessary (T. 1,577). (2-1)

<u>CONCLUSIONS OF LAW</u>

Respondent is charged with ninety-four specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" includes suggested definitions for negligence on more than one occasion, gross negligence, incompetence on more than one occasion, gross incompetence.

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

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

Gross Negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that 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 a significant or serious deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is 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 has potentially grave consequences. Post, supra, at 986.

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

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

The Department and Respondent both offered the testimony of medical experts. The Department presented testimony by Joel S. Cooper, M.D., and Respondent presented testimony by Robert H. Dropkin, M.D. Both physicians are board certified in obstetrics and gynecology. They were highly experienced in their area of medical expertise, and their testimony was thoughtful and forthright. The Hearing Committee found the testimony of these two witnesses to be equally credible.

The Department offered the testimony of Linda Tripoli, R.N. While the Committee found her to be credible, her testimony was as reliable as the unsworn statements given to her by others.

The Department offered the testimony of Catherine Sickler, L.P.N., as a fact witness to the events of November 23, 1998, involving Patient F. The Hearing Committee was concerned about the amount of time that had elapsed before Ms. Sickler came forward with the version of events which she testified to at the hearing, and the fact that Ms. Sickler had been employed by Respondent during a portion of that period. Further, several other health care workers were present as the events unfolded in November 1998, and none of those individuals appeared as a witness to corroborate her version of the events. As such, the Hearing Committee felt that they could not rely upon Ms. Sickler's testimony.

Respondent also testified. He has an obvious interest in the outcome of these proceedings, and the Committee evaluated his testimony accordingly. At times, his testimony was evasive and argumentative. At other times, he appeared more forthright. Several aspects of his testimony were troubling. The medical records of the patients contained no record of some of the conversations or actions which Respondent alleged in his testimony. For example, Respondent testified to a fairly thorough understanding of Patient A's cardiac condition, yet his medical record for that patient does not support his testimony. The Committee felt that it was unable to rely on much of Respondent's testimony, and instead relied on the medical records and the testimony of the two medical experts.

Cystoscopies of Patient A, Patient E and Patient G

The Department's expert testified that Respondent performed a cystoscopy without adequate and appropriate indication upon Patient A on two occasions and upon Patient E and Patient G on one occasion each. Respondent's expert testified with equal credibility that the cystoscopies performed were completely appropriate and within the standard of care. As such, the Hearing Committee found that the Department had not met its burden of proving these allegations by a preponderance of the evidence.

Patient Consent for a Cystoscopies

The Department's expert also testified that Respondent's failure to include a possible cystoscopy in the written consent form of Patient A, E and G was a departure from the accepted standard of care. Respondent's expert testified with equal credibility that the cystoscopies performed were part of the procedure for which Respondent had obtained the patient's consent, and that the cystoscopies were merely performed to ensure that no injury had occurred. Moreover, no patient testified that Respondent had failed to obtain her consent for a cystoscopy. Accordingly, the Hearing Committee found that the Department had not met its burden of proving these allegations by a preponderance of the evidence.

Cardiac Clearance for Patient A

Patient A had a history of heart disease including a

myocardial infarction, angina, mitral valve prolapse and an irregular heart rhythm. The Department's expert testified that Respondent's failure to obtain a clearance by a cardiologist or internist was a serious deviation from the standard of care, and that the potential risk of harm to Patient A was life-threatening. The Hearing Committee accepted the testimony of the Department's expert.

Respondent contended that his own assessment of the risk to the patient was sufficient, and that he had determined that the patient's risk assessment for the procedure was acceptable. The Hearing Committee rejected the testimony of Respondent's expert on this point because it was based upon a series of assumed contacts between Respondent and Patient A's cardiologist and primary care physician. Respondent's medical record for Patient A does not support contact with other physicians about Patient A's cardiac status immediately prior to the two surgeries, and the Committee did not find Respondent's testimony credible.

Patient B

Having considered the testimony of the two medical experts regarding Respondent's prenatal care of Patient B, the Hearing Committee determined that Respondent provided sufficient follow-up care and observation. According to the testimony of Respondent's expert, some elevation of blood pressure is normal during a pregnancy, and Patient B did not meet the criteria for the

administration of antihypertensive medication prior to her hospitalization.

When Patient B was admitted to the hospital on March 7, 2001, Respondent recognized the possibility of impending HELLP syndrome and ordered the necessary studies to confirm the condition. The Hearing Committee felt that the record demonstrated that Respondent had observed the patient with a reasonable degree of care. HELLP is very rare and cannot be prevented. The treatment is delivery, and an obstetrician has to use judgment regarding when that delivery should occur. The patient had low platelets, and a possible vaginal delivery had advantages over a C-section. Although there is no written order in the hospital chart for the administration of magnesium sulfate at 11:00 p.m., the later documented order for a continuation of the magnesium sulfate suggest that a prior order had been made. The Committee viewed the line in the Chart crossing out the latter order as mere artifact from the copying process. Respondent's expert credibly testified that he would not have managed the Patient B differently and that Respondent's actions were within the standard of care. Therefore, the Committee determined that the Department had not established a violation of the standard of care by a preponderance of the evidence.

Patient C

The Hearing Committee determined that Respondent was unable

to place a fetal scalp electrode because Patient C was not sufficiently dilated at the time. The initial opinion expressed by the Department's expert did not appear to take this factor into consideration.

The record establishes that Patient C was morbidly obese. A morbidly obese patient is exposed to an increased risk with a C-section, and an obstetrician must balance the risks to the mother and the fetus when making a decision about when a C-section should be performed. Ultimately, the Committee determined that Respondent exercised clinical judgment within the standard of care in the timing of the C-section performed on Patient C.

Respondent contended that some of his decisions were motivated by the limited facilities available in a small hospital. The Committee, on the other hand, was concerned that Respondent's decision to induce delivery of such a high-risk patient in this setting demonstrated a lack of awareness of his own limitations. Since Respondent's conduct in that regard was not raised in the Statement of Charges; however, the Committee did not use that conduct as a basis for imposing a penalty.

Patient D

The Hearing Committee accepted the testimony of Respondent's expert which indicated that Respondent exercised clinical judgment within the standard of care in the timing of the C-

section that he performed on Patient D. The Respondent's expert testified that the fetal monitoring strips showed good variability and no recurrent late decelerations from the time of Respondent's decision to perform a C-section and the incision. The fetus responded well to resuscitative measures, and the Apgar scores were 9, 9 and 10 at 1, 3 and 5 minutes. As previously stated, the Committee felt that the two experts were equally credible as witnesses, but that the Department had the burden of proof on the allegations charged.

Patient F

The Hearing Committee considered the conflicting statements regarding Respondent's insertion of the Veress needle and the trocar as well as the injury which occurred to Patient F during the laparotomy. The Hearing Committee felt that it could not rely upon the testimony of the Nurse Catherine Sickler related to the insertion of the trocar. On the other hand, the Department's expert appeared to rely heavily on Ms. Sickler's sworn statements. Both medical experts testified that trocar injuries are a recognized although extremely rare complication. As such, the injury to Patient F was possibly a rare, known complication for the procedure performed. Ultimately, the Committee concluded that the Department had not established by a preponderance of the evidence that Respondent had improperly inserted the Veress needle or trocar.

The Department did establish by a preponderance of the evidence that Respondent failed to respond appropriately when the code blue was called. Respondent had inserted a Veress needle and a trocar minutes before Patient F became hypotensive. At 9:13 a.m., a code blue was called according to the hospital record. An EKG was printed out at 9:16 a.m. indicating that Patient F's heart rate was 134.

Respondent contended that the code was called later than 9:13 a.m., and his expert offered speculative testimony regarding the length of time required to perform a hysteroscopy as a means of supporting Respondent's contention. The Hearing Committee did not find this testimony or explanation credible. The EKG record is consistent with a code being called three minutes earlier because it was likely performed to determine the cause of the patient's hypotension.

Respondent's expert testified that the anesthesiologist is responsible for the patient's cardiovascular status intraoperatively, and that it would have been inappropriate to perform a stat laparotomy at the initiation of the code. The Committee felt that this testimony was insufficient justification for Respondent's failure to diagnose the cause of the patient's hypotension and commence a laparotomy to stop the patient's bleeding. The Committee concluded that the explanation of a later start time for the code

blue was fabricated by Respondent to justify his failure to take prompt action to address Patient F's urgent medical condition. The Committee determined that the Department's expert testified clearly and persuasively that the standard of care required Respondent to perform promptly an exploratory laparotomy to stop the patient's bleeding.

Factual Allegations

In accordance with these Conclusions of Law and based upon the Findings of Fact set forth above, the Hearing Committee makes the following determinations regarding the factual allegations contained in the Statement of Charges. The first number contained in parentheses following each determination represents the number of committee members who voted to sustain the allegation, and the second number represents the number of committee members who voted not to sustain the allegation:

Paragraph A - A.1	Sustained (2-1)
Paragraph A - A.2	Sustained (2-1)
Paragraph A - A.3	Not Sustained (1-2)
Paragraph A - A.4	Not Sustained (1-2)
Paragraph A - A.5	Not Sustained (1-2)
Paragraph A - A.6	Not Sustained (1-2)
Paragraph B - B.1	Not Sustained (0-3)

Paragraph B - B.2	Not Sustained (0-3)
Paragraph B - B.3	Not Sustained (1-2)
Paragraph B - B.4	Not Sustained (1-2)
Paragraph B - B.5	Not Sustained (0-3)
Paragraph B - B.6	Not Sustained (0-3)
Paragraph B - B.7	Not Sustained (0-3)
Paragraph B - B.8	Not Sustained (1-2)
Paragraph B - B.9	Not Sustained (0-3)
Paragraph B - B.10	Not Sustained (1-2)
Paragraph C - C.1	Not Sustained (0-3)
Paragraph C - C.2	Not Sustained (1-2)
Paragraph C - C.3	Not Sustained (1-2)
Paragraph D - D.1	Not Sustained (1-2)
Paragraph E - E.1	Not Sustained (1-2)
Paragraph E - E.2	Not Sustained (1-2)
Paragraph F - F.1	Not Sustained (0-3)
Paragraph F - F.2	Not Sustained (0-3)
Paragraph F - F.3	Sustained (3-0)
Paragraph G - G.1	Not Sustained (1-2)
Paragraph G - G.2	Not Sustained (1-2)

Specifications

The first through eighteenth specifications charged

Respondent with practicing with gross negligence on a particular occasion, in violation of New York Education Law §6530(4). As discussed in detail above, the Hearing Committee found Respondent's failure to obtain an appropriate cardiac clearance prior to the procedures he performed upon Patient A constituted one specification of gross negligence. By a 2-1 vote, one specification of gross negligence is **Sustained**.

The nineteenth through thirty-sixth specifications charged Respondent with practicing with gross incompetence within the meaning of New York Education Law §6530(6). As discussed in detail above, the Hearing Committee determined that Respondent demonstrated gross incompetence during his care of Patient F when he failed to appropriately respond to a code blue during surgery. As a result, one specification of gross incompetence is **Sustained.**

The thirty-seventh through sixty-third specifications charged Respondent with practicing with negligence on more than one occasion within the meaning of New York Education Law §6530(3). As discussed in detail above, the Hearing Committee determined that the Respondent was negligent in his care of Patient A on two occasions. As a result, one specification of practicing with negligence on more than one occasion is **Sustained.**

The sixty-fourth through ninetieth specifications charged Respondent with practicing with incompetence on more than one

occasion within the meaning of New York Education Law §6530(5). As discussed in detail above, the Hearing Committee determined that the Respondent was incompetent in his care of Patient F on only one occasion. As a result, the specifications related to incompetence on more than one occasion are **Dismissed.**

The ninety-first through ninety-fourth specifications charged Respondent with performing professional services not authorized within the meaning of New York Education Law §6530(26). As discussed above, the Hearing Committee determined that the Department did not establish the allegations charged. As a result, these specifications are **Dismissed.**

DETERMINATION AS TO PENALTY

Petitioner recommended that, at the least, Respondent be subject to a suspension of his license, a period of probation, practice oversight by a supervisor or monitor, retraining, and a fine. Respondent asked that the charges be dismissed in their entirety.

The specifications of misconduct sustained relate to matters associated with Respondent's surgical practice. The Hearing Committee felt Respondent failed to comprehend the seriousness of performing a surgery on Patient A without obtaining an appropriate clearance from a cardiologist or internist. The Committee's concern

regarding Respondent's lack of awareness of his own limitations in making this assessment was heightened by Respondent's failure to respond to the code blue that was called for Patient F. The Committee feels that permitting Respondent to perform surgeries without the immediate availability of another qualified surgeon to perform the operation would place his patients at serious risk. The Hearing Committee, therefore, imposes a permanent limitation on Respondent's license. Respondent's license is limited to prohibit Respondent from performing any surgery unless another qualified surgeon is present in the operating room and prepared to perform the surgery if necessary. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

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

1. The First, Second and Thirty-sixth Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED;**

2. The Thirty-seventh and Thirty-eighth Specifications of professional misconduct, as set forth in the Statement of Charges are deemed to constitute one specification of negligence on more than one

occasion. As such, the Thirty-seventh/Thirty-eighth Specification is **SUSTAINED**;

2. The Third through Thirty-fifth and Thirty-ninth through Ninety-fourth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State is hereby **PERMANENTLY LIMITED** to prohibit Respondent from performing any surgery unless another qualified surgeon is present in the operating room and prepared to perform the surgery if necessary;

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

DATED: New York, New York
December 7, **2009**

Redacted Signature

JERRY WAISMAN (CHAIR)

ELEANOR KANE, M.D.
MARY ANN CRESANTI, N.P.

TO: Jeffrey J. Conklin, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
2517 Corning Tower
Empire State Plaza
Albany, New York 12237

John T. Maloney, Esq.
Carter, Conboy, Case,
Blackmore, Maloney & Laird P.C.
Attorney for Respondent
20 Corporate Woods Boulevard
Albany, New York 12211-2362

Khalid Parwez, M.D.
59 River Street
Sidney, New York 13838

APPENDIX I

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

IN THE MATTER OF KHALID PARWEZ, M.D.	NOTICE OF HEARING

TO: Khalid Parwez, M.D.
c/o John Maloney, Esq.
Carter, Conboy, Case, Blackmore, Maloney & Laird, P.C.
20 Corporate Woods
Albany, New York 12211

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on, at 10:00 a.m., on April 2, 2009, and continuing on April 3, 2009, in Albany, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication,

Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES F. HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 27, 2009

Redacted Signature

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

Inquiries should be directed to: Jeffrey J. Conklin, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
Room 2512, Corning Tower
Empire State Plaza
Albany, New York 12237
(518) 473-4219

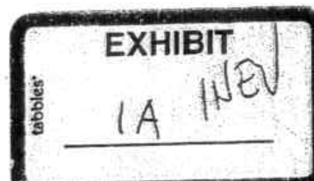
NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF KHALID PARWEZ , M.D.	AMENDED STATEMENT OF CHARGES

KHALID PARWEZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 17,1976, by the issuance of license number 128379 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided gynecologic and obstetric medical care to Patient A (all patients are identified in the attached Appendix) at Respondent's office and at The Hospital, both facilities located in Sydney, New York, at various times from on or about December 2001 through February 2003. Patient A was admitted to The Hospital on January 30, 2002, for a scheduled hysteroscopy, left salpingo laparoscopy, oophorectomy and possible laparotomy. Patient A had an admitting diagnosis of dysfunctional uterine bleeding, a left ovarian cyst and pelvic pain. Patient A had a history of angina and had a myocardial infarction on or about June 1988. Patient A had also been hospitalized for chest pain in July and September 2001, and had undergone three cardiac catheterizations, the last of which was performed on or about April 2000. On or about January 30, 2002, Patient A underwent a hysteroscopy, resection of the polypoid endometrium, laparoscopic fulgurating of the endometriosis of the cul de sac and right ovary, and a cystoscopy. Patient A's pain continued after these procedures and she underwent further treatment. On or about March 13, 2002, Patient A was admitted to The Hospital for a scheduled total abdominal



hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO). Subsequently, Patient A underwent a TAH and BSO, together with a cystoscopy. Respondent's care of Patient A failed to meet accepted standards of medical practice in that:

1. Respondent failed to obtain appropriate and indicated medical and/or cardiac clearances prior to the procedures performed upon Patient A on or about January 30, 2002.
2. Respondent failed to obtain appropriate and indicated medical and/or cardiac clearances prior to the procedures performed upon Patient A on or about March 13, 2002.
3. Respondent performed a cystoscopy, without adequate and appropriate medical indications, upon Patient A on or about January 30, 2002;
4. Respondent performed a cystocopy, without adequate and appropriate medical indications, upon Patient A on or about March 13, 2002.
5. Respondent failed to obtain a written informed consent from Patient A for the cystoscopy performed on said patient on or about January 30, 2002.
6. Respondent failed to obtain a written informed consent from Patient A for the cystoscopy performed on said patient on or about March 13, 2002.

B. Respondent provided gynecologic and obstetric medical care to Patient B at Respondent's office and The Hospital at various times from on or about February 11, 1997, through on or about June 2001. Patient B was admitted to the Labor and Delivery Unit of The Hospital on March 8, 2001, with hypertension and complaints of sharp abdominal pain, nausea, vomiting, mild contractions, and edema of the hands and feet. Patient B underwent a Cesarean section on or about the 8th day of March, 2001. Respondent's care

of Patient B failed to meet accepted standards of medical practice in that:

1. From on or about Patient B's 31st week of gestation, Respondent failed to appropriately manage said patient's prenatal care.

2. From on or about Patient B's 31st week of gestation, Respondent failed to appropriately observe and/or treat said patient for elevated blood pressure.

3. Respondent failed to appropriately observe and/or treat Patient B for elevated liver enzymes during said patient's admission to The Hospital commencing on or about March 7, 2001.

4. Respondent failed to appropriately and/or timely order indicated serial studies of Patient B's liver enzymes during said patient's admission to The Hospital commencing on or about March 7, 2001.

5. Respondent failed to appropriately observe and/or treat Patient B for elevated blood pressure during said patient's admission to The Hospital commencing on or about March 7, 2001.

6. Respondent failed to appropriately and/or timely order indicated serial studies of Patient B's blood pressure during said patient's admission to The Hospital commencing on or about March 7, 2001.

7. Respondent failed to appropriately and/or timely order indicated anti-hypertensive therapy for Patient B during said patient's admission to The Hospital commencing on March 7, 2001.

8. Respondent failed to appropriately and/or timely treat Patient B for hemolysis, and/or elevated liver enzymes, and/or low platelet count (HELLP syndrome) during said patient's admission to The Hospital commencing on March 7, 2001.

9. Respondent failed to timely begin indicated magnesium sulfate for Patient B during said patient's admission to The Hospital commencing on or about March 7, 2001.

10. Respondent failed to appropriately and/or timely perform a Cesarean section upon Patient B.

C. Respondent provided gynecologic and obstetric medical care to Patient C at The Hospital from on or about February 9, 2004, through February 13, 2004. Patient C was admitted to The Hospital on or about February 9, 2004, due to prolonged contractions of one week duration, severe back and pelvic pain, and decreased fetal movement. Patient C underwent a Cesarean section on or about the 10th day of February, 2004. Respondent's care of Patient C failed to meet accepted standards of medical practice in that:

1. Respondent failed to place an indicated fetal scalp electrode upon Patient C's fetus.

2. Respondent failed to appropriately and/or timely treat Patient C for fetal tachycardia and/or bradycardia.

3. Respondent failed to appropriately and/or timely perform an indicated Cesarean section upon Patient C.

D. Respondent provided gynecologic and obstetric medical care to Patient D at The Hospital from on or about August 25, 2003, through on or about August 28, 2003. The patient was admitted to The Hospital on August 25, 2003, for a scheduled induction of labor. The fetus was in distress with late decelerations

of the fetal heart rate. Respondent made the decision to perform a Cesarean section upon Patient D on or about August 25, 2003. A Cesarean section was performed on Patient D on said date. Respondent's care of Patient D failed to meet accepted standards of medical practice in that:

1. Respondent failed to appropriately and/or timely perform an indicated Cesarean section upon Patient D.

E. Respondent provided gynecologic and obstetric medical care to Patient E at the Respondent's office and at The Hospital from on or about September 19, 2001, through on or about October 19, 2001. The patient was admitted to The Hospital on October 4, 2001, for a scheduled dilatation and curettage, (D&C), laparoscopy, right oophorectomy, tubal ligation and laparotomy, if necessary. Patient E, who had a spontaneous abortion a week prior, had a history of dysfunctional uterine bleeding, solid right adnexal mass and severe right lower quadrant pain. Patient E underwent a D & C, and laparoscopy, which was converted to a laparotomy, excision of hemorrhagic left tubal ovarian mass, and left partial salpingectomy. Respondent's care of Patient E failed to meet accepted standards of medical practice in that:

1. Respondent performed a cystoscopy, without adequate and appropriate medical indications, upon Patient E on or about October 4, 2001.
2. Respondent failed to obtain a written informed consent from Patient E for the cystoscopy performed on said patient on or about October 4, 2001.

F. Respondent provided gynecologic and obstetric medical care to Patient F at Respondent's office and at The Hospital, at various times from on or about January 1997 through on or about November 1998. The patient was admitted to The Hospital on or about November 23, 1998, for a scheduled hysteroscopy and laparoscopy. Patient F had a history of dysfunctional uterine bleeding, post-

coital bleeding and recurrent pelvic pain. Patient F underwent a hysteroscopy and laparoscopy. After the surgical procedure was commenced, Patient F became hypotensive. Later it was determined that Patient F had sustained injuries to her abdominal aorta and vena cava, among other injuries, during the surgical procedure. Respondent's care of Patient F failed to meet accepted standards of medical practice in that:

1. Respondent failed to appropriately insert the trocar when performing the surgical procedure upon Patient F on November 23, 1998.
2. Respondent failed to appropriately insert the veress needle when performing the surgical procedure upon Patient F on November 23, 1998.
3. Respondent failed to appropriately respond to a "code blue" which was called the surgical procedure upon Patient F on November 23, 1998.

G. Respondent provided gynecologic and obstetric medical care to Patient G at Respondent's office and The Hospital at various times from on or about March 21,1998, through on or about August 2002. Patient G was admitted to The Hospital on or about April 29, 2002, for a scheduled hysteroscopy ablation, laparoscopy fulguration of endometriosis, and bilateral tubal coagulation. Patient G had a history of endometrial hyperplasia, adenomyosis, irregular vaginal bleeding and chronic pelvic pain. On or about July 9, 2002, Patient G was admitted to The Hospital for a scheduled TAH. Patient G underwent a TAH, together with a cystoscopy. Respondent's care of Patient G failed to meet accepted standards of medical practice in that:

1. Respondent performed a cystoscopy, without appropriate and adequate medical indications, upon Patient G on or about July 10, 2002.

2. Respondent failed to obtain a written informed consent from Patient G for the cystoscopy performed on said patient on or about July 10, 2002.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTEENTH 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 in Paragraphs A and A1.
2. The facts in Paragraphs A and A2.
3. The facts in Paragraphs B and B1.
4. The facts in Paragraphs B and B2.
5. The facts in Paragraphs B and B3.
6. The facts in Paragraphs B and B4.
7. The facts in Paragraphs B and B5.
8. The facts in Paragraphs B and B6.
9. The facts in Paragraphs B and B7.
10. The facts in Paragraphs B and B8.
11. The facts in Paragraphs B and B9.
12. The facts in Paragraphs B and B10.
13. The facts in Paragraphs C and C1.
14. The facts in Paragraphs C and C2.
15. The facts in Paragraphs C and C3.
16. The facts in Paragraphs F and F1.
17. The facts in Paragraphs F and F2.
18. The facts in Paragraphs F and F3.

NINTEENTH THROUGH THIRTY-SIXTH 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:

19. The facts in Paragraphs A and A1.
20. The facts in Paragraphs A and A2.
21. The facts in Paragraphs B and B1.
22. The facts in Paragraphs B and B2.
23. The facts in Paragraphs B and B3.
24. The facts in Paragraphs B and B4.
25. The facts in Paragraphs B and B5.
26. The facts in Paragraphs B and B6.
27. The facts in Paragraphs B and B7.
28. The facts in Paragraphs B and B8.
29. The facts in Paragraphs B and B9.
30. The facts in Paragraphs B and B10.
31. The facts in Paragraphs C and C1.
32. The facts in Paragraphs C and C2.
33. The facts in Paragraphs C and C3.
34. The facts in Paragraphs F and F1.
35. The facts in Paragraphs F and F2.
36. The facts in Paragraphs F and F3.

THIRTY-SEVENTH THROUGH SIXTY-THIRD SPECIFICATIONS

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:

37. The facts in Paragraphs A and A1.
38. The facts in Paragraphs A and A2.
39. The facts in Paragraphs A and A3.
40. The facts in Paragraphs A and A4.
41. The facts in Paragraphs A and A5.

42. The facts in Paragraphs A and A6.
43. The facts in Paragraphs B and B1.
44. The facts in Paragraphs B and B2.
45. The facts in Paragraphs B and B3.
46. The facts in Paragraphs B and B4.
47. The facts in Paragraphs B and B5.
48. The facts in Paragraphs B and B6.
49. The facts in Paragraphs B and B7.
50. The facts in Paragraphs B and B8.
51. The facts in Paragraphs B and B9.
52. The facts in Paragraphs B and B10.
53. The facts in Paragraphs C and C1.
54. The facts in Paragraphs C and C2.
55. The facts in Paragraphs C and C3.
56. The facts in Paragraphs D and D1.
57. The facts in Paragraphs E and E1.
58. The facts in Paragraphs E and E2.
59. The facts in Paragraphs F and F1,
60. The facts in Paragraphs F and F2.
61. The facts in Paragraphs F and F3.
62. The facts in Paragraphs G and G1.
63. The facts in Paragraphs G and G2.

SIXTY-FOURTH THROUGH NINETIETH SPECIFICATIONS

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:

64. The facts in Paragraphs A and A1.

65. The facts in Paragraphs A and A2.

66. The facts in Paragraphs A and A3.

67. The facts in Paragraphs A and A4.

68. The facts in Paragraphs A and A5.

69. The facts in Paragraphs A and A6.

70. The facts in Paragraphs B and B1.

71. The facts in Paragraphs B and B2.

72. The facts in Paragraphs B and B3.

73. The facts in Paragraphs B and B4.

74. The facts in Paragraphs B and B5.

75. The facts in Paragraphs B and B6.

76. The facts in Paragraphs B and B7.

77. The facts in Paragraphs B and B8.

78. The facts in Paragraphs B and B9.

79. The facts in Paragraphs B and B10.

80. The facts in Paragraphs C and C1.

81. The facts in Paragraphs C and C2.

82. The facts in Paragraphs C and C3.

83. The facts in Paragraphs D and D1.

84. The facts in Paragraphs E and E1.

85. The facts in Paragraphs E and E2.

86. The facts in Paragraphs F and F1,

87. The facts in Paragraphs F and F2.

88. The facts in Paragraphs F and F3.

89. The facts in Paragraphs G and G1.

90. The facts in Paragraphs G and G2.

NINETY-FIRST THROUGH NINETY-FOURTH SPECIFICATIONS

PERFORMING PROFESSIONAL SERVICES NOT AUTHORIZED

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(26) by performing professional services which have not been duly authorized by the patient or his or her legal representative as alleged in the facts of the following:

91. The facts in Paragraphs A and A5.
92. The facts in Paragraphs A and A6.
93. The facts in Paragraphs E and E2.
94. The facts in Paragraphs G and G2.

DATED: April 8, 2009
Albany, New York

Redacted Signature

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