Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

December 21, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ayodeji Lukula, M.D.
REDACTED

Cindy Marie Fascia, Esq.
NYS Department of Health
ESP–Corning Tower-Room 2509
Albany, New York 12237

RE: In the Matter of Ayodeji Lukula, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-273) 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.

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

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

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

IN THE MATTER

OF

AYODEJI LUKULA, M.D.

DETERMINATION

AND

ORDER

BPMC #10-273

William P. Dillon, M.D. (Chair), Donald Cherr, M.D., and William Walence, PH.D duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law. Christine C. Traskos Esq., Administrative Law Judge, ("**ALJ**") served as the Administrative Officer.[1]

The Department of Health appeared by Cindy Marie Fascia, Esq., Associate Counsel. Respondent, Ayodeji Lukula, M.D. did not appear personally and was not represented by Counsel.

Evidence was received and examined. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges: October 7, 2010

Date of Service of Notice of Hearing and Statement of Charges: October 14, 2010 (see discussion below)

[1]Administrative Law Judge John H. Terepka presided at the hearing on November 15, 2010.

Date of Answer to Charges:	None submitted
Pre-Hearing Conference :	November 1, 2010
Date of Hearing :	November 15, 2010
Location of Hearing:	New York State Department of Health 217 South Salina Street Syracuse, NY 13202
Witness for the Petitioner:	David Gandell, M.D.
Deliberations Date:	November 15, 2010
Transcript received:	November 24, 2010

On November 1, 2010, the ALJ held a pre-hearing conference. Respondent did not appear at this pre-hearing and no counsel appeared on his behalf. At that pre-hearing, the ALJ ruled that the service of the Notice of Hearing and Statement of Charges on Respondent was effected on October 14, 2010 by personal service and that the Board for Professional Medical Conduct had obtained jurisdiction over Respondent (Pre-hearing T. 5)[2]; (Petitioner's Exhibit 2)[3]

On November 8, 2010, the Petitioner made a written motion to have the charges deemed admitted based on Respondent's failure to file an answer. (ALJ Exhibit 3) The Notice of Hearing (Department's Exhibit 1) at page 2 states:

> 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

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[2] Numbers in brackets refer to Hearing transcript page numbers (T.)

[3]- Refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit #). No exhibits were submitted by Respondent.

the hearing. Any charge or allegation not so answered shall be deemed admitted. (Underline in original)

Public Health Law §230(10)(c) clearly indicates that the failure to file a written answer will result in the charges and allegations being deemed admitted. Due to Respondent's failure to submit a written answer, the ALJ ruled in a letter dated November 8, 2010, that the factual allegations and charges of misconduct contained in the Statement of Charges (Department's Exhibit 1) were deemed admitted by Respondent (ALJ Exhibit 4). See also Corsello v. New York State Department of Health, 300 A.D.2d 849, 752 N.Y.S.2d 156 (App. Div. 3rd Dep't. 12/19/2002).

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York ["**P.H.L.**"]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" or "**Department**") pursuant to §230 of the P.H.L. Ayodeji Lukula, M.D. ("**Respondent**") is charged with twenty-seven (27) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: practicing with negligence on more than one occasion, practicing with incompetence on more than one occasion, practicing with gross negligence, practicing with gross incompetence, violating any term of probation or condition or limitation, failing to maintain accurate records for patients, practicing medicine fraudulently and making or filing a false report.

Respondent failed to submit an answer and therefore all the Factual Allegations and all the Specifications of Misconduct contained in the Statement of Charges are deemed admitted. A copy

of the Notice of Hearing and the Statement of Charges is attached to this Determination and Order as Appendix 1.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent testimony and/or documentary evidence found persuasive by the Hearing Committee in arriving at a particular finding. The Petitioner, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact.

1. Respondent was authorized to practice medicine in New York State on or about December 8, 1993 by the issuance of license number 193051 by the New York State Education Department.

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent. (determination made by the ALJ); (P.H.L. §230(10)(d)); (Petitioner's Ex. 1,2); (Pre-Hearing T. 5)

Patient A

3. Respondent provided medical care to Patient A on various occasions from on or about February 15, 2001 through on or about February 13, 2007, at Respondent's office, Cayuga Women's Health Services, then located at 143 North Street, Auburn, New York, and at Auburn Memorial Hospital.

4. Respondent failed to maintain a medical record for Patient A in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient A.

5. Respondent, from on or about October 15, 2002 through on or about September 16,

2003 provided obstetrical care to Patient A, including pre-natal and post-partum care.

6. Respondent failed to adequately manage and/or to document management of Patient A's gestational diabetes.

7. Respondent failed to order, perform or to refer Patient A for performance of a detailed anatomic ultrasound.

8. Respondent documented that Patient A was a Type 1-B gestational diabetic, when such a designation does not exist and/or when said designation was incorrect.

9. Respondent failed to order adequate monitoring of Patient A's fetus during her pregnancy, including non-stress tests.

10. Respondent inappropriately utilized "placental grading" in assessing the well-being of Patient A's fetus.

11. Respondent, in his post-partum care of Patient A, treated her with multiple courses of antibiotics without culture or physical evidence of infection.

12. Respondent, on or about February 13, 2007, prescribed Femcon, an oral contraceptive, for Patient A's irregular vaginal bleeding.

13. Respondent prescribed an oral contraceptive for Patient A despite the fact that Patient A was an insulin dependent diabetic and a smoker.

14. Respondent prescribed an oral contraceptive for Patient A, who also presented with a breast lump at that office visit, without adequately evaluating Patient A's breast lump.

15. Respondent prescribed an oral contraceptive for Patient A's irregular vaginal bleeding without adequately evaluating Patient A for the cause of said bleeding and/or without adequately evaluating Patient A for her abnormal uterine findings.

16. Respondent prescribed an oral contraceptive for Patient A without taking and/or

recording her blood pressure.

17. Respondent made or caused to be made a false entry in Patient A's medical records.

18. Respondent's medical records for Patient A are not adequately legible.

Patient B

19. Respondent provided medical care to Patient B from on or about November 29, 2007, through on or about June 16, 2008, at Cayuga Women's Health Services (Respondent's office).

20. Respondent, after his hospital privileges at Auburn Memorial Hospital were suspended on or about April 23, 2008, continued to provide pre-natal care for Patient B without promptly notifying Patient B that he had no hospital privileges and could not provide care to her in a hospital setting.

21. Respondent, after Patient B had transferred her prenatal care to another physician, failed to promptly make Patient B's medical record available to the subsequent treating physician, despite repeated requests and despite the fact that Patient B was near term.

22. Respondent failed to fax or otherwise timely provide a copy of Patient B's prenatal record to Auburn Memorial Hospital on or about June 16, 2008, when Respondent had advised Patient B's husband and/or Patient B that she should be brought to Auburn Memorial Hospital for evaluation.

23. Respondent failed to order or perform detailed anatomic ultrasound during the course of Patient B's pregnancy.

24. Respondent failed to maintain a medical record for Patient B in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient B.

25. Respondent's medical records for Patient B are not adequately legible.

26. Respondent, when his medical malpractice insurance had lapsed for nonpayment, and when he was practicing in violation of his Consent Order with OPMC, continued to provide prenatal care in his office to Patient B.

Patient C

27. Respondent provided medical care to Patient C on various occasions from on or about March 12, 1997 through on or about April 9, 2008 at Respondent's office and at Auburn Memorial Hospital.

28. Respondent, on or about May 3, 2007, when Patient C presented for and/or requested screening for sexually transmitted disease, failed to adequately evaluate the patient for sexually transmitted diseases.

29. Respondent, despite Patient C's history of having previously given birth to an infant with a lethal cardiac defect, failed to adequately assess the fetal heart during Patient C's pregnancy in 2007-2008.

30. Respondent, despite Patient C's history of hypertension, failed to perform non-stress tests.

31. Respondent failed to adequately assess Patient C's history of a preterm birth.

32. Respondent failed to make a timely diagnosis of gestational diabetes in Patient C, and made a misleading and/or inaccurate entry in Patient C's hospital record regarding the management and control of Patient C's gestational diabetes.

33. Respondent, on or about March 25, 2008, admitted Patient C to Auburn Memorial Hospital for delivery.

34. Respondent, after making two failed attempts to perform a vacuum delivery, waited approximately 45 minutes before attempting a third time to perform a vacuum delivery of

Patient C's infant.

35. Respondent, after making two failed attempts to perform a vacuum delivery, failed to timely perform a cesarean section.

36. Respondent failed to adequately document his attempts to perform an operative vaginal delivery.

37. Respondent inaccurately and/or inadequately documented that there had been a failed attempt at a forceps delivery of Patient C's infant.

38. Respondent, on various occasions during the course of his treatment of Patient C, ordered and/or treated Patient C with antibiotics without adequate indication or evaluation and/or diagnosed Patient A with various conditions without adequate indication or evaluation.

39. Respondent failed to maintain a medical record for Patient C in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient C.

40. Respondent's medical records for Patient C are not adequately legible.

Patient D

41. Respondent provided medical care to Patient D, during a pregnancy with an estimated date of delivery in January 2006, at Respondent's office and at Auburn Memorial Hospital.

42. Respondent failed to maintain a medical record for Patient D in accordance with accepted medical standards and/or in a manner which adequately reflected his care and treatment of Patient D.

43. Respondent failed to adequately monitor or respond to Patient D's blood glucose levels during the pregnancy.

44. Respondent failed to adequately instruct Patient D concerning glucose monitoring.

45. Respondent failed to take adequate steps to attempt control of Patient D's blood sugar or to seek appropriate consultation.

46. Respondent diagnosed Patient D as having gestational diabetes when she had been diagnosed as diabetic before the pregnancy.

47. Respondent planned a glucose challenge test for Patient D, a known diabetic.

48. Respondent failed to order or perform detailed anatomic ultrasound during the course of Patient D's pregnancy.

49. Respondent, on various occasions, diagnosed Patient D as having urinary tract infection, cystitis, and vaginosis without adequate evaluation or cultures.

50. Respondent ordered antibiotics for Patient D's diagnoses of urinary tract infections, or cystitis, or rash without adequate indication.

51. Respondent failed to document his plan or rationale to induce labor in December 2005. Respondent did not adequately document in Patient D's hospital record why Patient D was admitted to the hospital in December 2005 or the status of the patient at that time.

52. Respondent admitted Patient D to the hospital for induction without adequate indication and/or without documentation of assessment of fetal lung maturity.

53. Respondent's medical records for Patient D are not adequately legible.

Patient E

54. Respondent treated Patient E from approximately 2004 to 2006, at Respondent's office and at Auburn Memorial Hospital.

55. Respondent inappropriately or inaccurately diagnosed Patient E with mennorrhagia when the correct diagnosis was metrorrhagia.

56. Respondent, following his performance of a hysteroscopy in 2004, inappropriately or inaccurately diagnosed Patient E as having an enlarged uterus with a submucous fibroid.

57. Respondent inappropriately or inaccurately interpreted an ultrasound in 2006 as showing bilateral ovarian cysts.

58. Respondent did not adequately document his rationale or discussions with Patient E, who was pre-menopausal, for removal of both her ovaries.

59. Respondent, on or around May 12, 2006, planned to perform a hysterectomy and bilateral salpingo-oophorectomy on Patient E without adequate indication.

60. Respondent, on or around May 12, 2006, planned to perform a hysterectomy and bilateral salpingo-oophorectomy on Patient E without adequate informed patient consent.

61. Respondent, after an operation on May 12, 2006, inappropriately or inaccurately described in his operative note that Patient E 's uterus was 8 weeks size.

62. Respondent, after an operation on May 12, 2006, inappropriately or inaccurately diagnosed Patient E as having endometriosis.

63. Respondent, on or about May 12, 2006, removed a normal ovary from Patient E without adequate indication.

64. Respondent's operative note of May 12, 2006, is not sufficiently understandable to describe the surgery he performed or his decision-making process during surgery.

65. Respondent's records for Patient E are not adequately legible.

66. Respondent failed to maintain a medical record for Patient E that was in accordance with accepted medical standards and/or in a manner which accurately reflected his care and treatment of Patient E.

Patient F

67. Respondent treated Patient F from approximately 1996 until approximately 2004, at his office and at Auburn Memorial Hospital.

68. Respondent diagnosed Patient F as having vaginosis and treated her for vaginosis without adequate evaluation and diagnostic testing.

69. Respondent diagnosed and treated Patient F as having chlamydia, a sexually transmitted disease, without adequate evaluation and cultures.

70. Respondent diagnosed Patient F as having uterine fibroids after a sonogram performed on Patient F noted "no fibroid".

71. Respondent admitted Patient F to Auburn Memorial Hospital on or about August 15, 1997 for a LAVH (laparoscopic assisted vaginal hysterectomy). Respondent's admitting note stated that the patient had "large uterine fibroids, about 15 week size", or words to such effect, without adequate basis.

72. Respondent failed to perform adequate endometrial evaluation of Patient F before the surgery of August 15, 1997.

73. Respondent made preoperative diagnoses for Patient F of mennorrhagia, an enlarged uterus and barrel shaped cervix, yet failed to obtain adequate evaluation of Patient F prior to surgery.

74. Respondent, in his operative note for Patient F, reported finding a uterus with multi-nodular fibroid and adenomyosis, when there was neither.

75. Respondent's operative note of August 15, 1997, is not sufficiently understandable to describe Respondent's surgery on Patient For his decision-making during surgery.

76. Respondent performed inadequate surgery on August 15, 1997, and/or failed to refer

Patient F for definitive surgery after the diagnosis of cancer was made.

77. Respondent failed to provide, refer or otherwise assure adequate followup or a treatment plan for the reported moderate to well-differentiated adenocarcinoma in Patient F's uterus, extending into the endocervical canal and fallopian tube.

78. Respondent failed to adequately or accurately discuss or document his discussion with Patient F concerning the cancer findings and appropriate options for treatment after the August 1997 surgery.

79. Respondent failed to refer Patient F in January 1998 when he documented and/or expressed concern in her medical record of possible recurrent cancer.

80. Respondent failed to inform or to document informing other subsequent treating physicians of Patient F's history of cancer.

81. Respondent diagnosed Patient F as having urinary tract infection, yeast infection, and mixed monilial discharge and treated her with medications without adequate evaluation or cultures.

82. Respondent, after the August 15, 1997 surgery and subsequent pathology reports, signed documents stating Patient F had a fibroid uterus when he knew or should have known that diagnosis was inaccurate.

83. Respondent failed to maintain a medical record for Patient F that was in accordance with accepted medical standards and/or in a manner which accurately reflected his care and treatment of Patient F.

Patient G

84. Respondent treated Patient G from approximately 2002 to approximately 2006, including during a pregnancy with an estimated due date in April 2006, at his office and at Auburn Memorial Hospital.

85. Respondent's records for Patient G are not adequately legible.

86. Respondent failed to take adequate histories during the pregnancy concerning Patient

G's drug, alcohol, and tobacco use.

87. Respondent failed to obtain adequate fetal assessment despite his documentation that Patient G was a drug abuser with a history of tobacco use.

88. Respondent failed to obtain adequate anatomic fetal ultrasound assessment.

89. Respondent failed to timely administer Rhogam to Patient G and/or to document timely administration.

90. Respondent failed to maintain a medical record for Patient G in accordance with accepted medical standards and/or in a manner which accurately reflects his care and treatment of Patient G.

91. Respondent entered into a Consent Order, BPMC Order No. 05-172 (hereafter BPMC No. 05-172), which Order became effective on or about August 16, 2005. Respondent, under the terms of BPMC No. 05-172, was subject to certain conditions, and a three year period of probation.

92. Respondent, pursuant to Paragraph/Probation Term 9 (e) of BPMC No. 05-172, was ordered to maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230 (18) (b) of the Public Health Law. Respondent, while the terms of probation and conditions of BPMC No. 05-172 were in effect, and/or while Respondent was engaged in the practice of medicine in New York State, failed to maintain the required medical malpractice coverage.

93. Respondent, pursuant to Paragraph/Probation Term 7 of BPMC No. 05-172, was required to maintain complete and legible medical records that accurately reflect his evaluation, treatment and plan for patients. Respondent, while the terms of probation and conditions of BPMC No. 05-172 were in effect, failed to maintain medical records which met the requirements of this term of probation.

CONCLUSIONS OF LAW

The Hearing Committee makes the unanimous conclusion, pursuant to the Findings of Fact listed above, that all the Factual Allegations contained in the October 7, 2010 Statement of Charges are **SUSTAINED**.

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee unanimously concludes that ALL THE SPECIFICATIONS OF MISCONDUCT contained in the Statement of Charges are **SUSTAINED.**

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

DISCUSSION

Respondent is charged with twenty-seven (27) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. The Hearing Committee determined that all of the allegations and all of the charges contained in the Statement of Charges were established by a preponderance of the evidence.

Respondent did not appear at the hearing, either in person or by counsel. His failure to file an answer to the Statement of Charges that were properly served upon him, resulted in the admission of the allegations and charges of misconduct outlined in the Notice of Hearing. The Hearing Committee concludes that Respondent chose to ignore the Notice of Hearing even though he was personally served with the notice. He made no attempts to respond or contact the Department or the ALJ after he became aware of these proceedings.

In addition to the fact that the allegations are deemed admitted, the Hearing Committee concludes that the documentary evidence and the credible testimony of David Gandell, M.D. sustains the allegations independently. The Hearing Committee found that Dr. Gandell provided a persuasive, detailed summary of the medical issues to corroborate the charges. They also concur with Dr. Gandell's assessment that Respondent's knowledge base is "grossly deficient" and that Patient F died unnecessarily due to Respondent's negligence and incompetence. (T.62,66)

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, a unanimous Hearing

Committee determines that Respondent's license to practice medicine in the State of New York should be revoked. This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including revocation, suspension, and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee finds that Respondent not only violated his probation, but also committed numerous acts of gross negligence and gross incompetence. The Hearing Committee believes that Respondent is a danger to any patient seen by him and he cannot be allowed to practice in New York State. They conclude that revocation is the appropriate penalty to safeguard the public.

ORDER

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

1. The FIRST through TWENTY-SEVENTH SPECIFICATIONS contained in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

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

DATED: Buffalo, New York
DECEMBER 20TH, 2010

REDACTED

WILLIAM P. DILLON, (Chair)
DONALD CHERR, M.D.
WILLIAM WALENCE, PH.D

Ayodeji Lukula, M.D.
REDACTED

Cindy Marie Fascia, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower- 25th Fl.
Empire State Plaza
Albany, NY 12237

APPENDIX 1

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

IN THE MATTER

OF

AYODEJI LUKULA, M.D.

NOTICE
OF
HEARING

TO: Avodeji Lukula, M.D.
REDACTED

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 November 15, 2010, at 10:00 a.m., at the Offices of the New York State Department of Health, Syracuse Regional Office, 4th Floor, Conference Room A/B, 217 South Salina Street, Syracuse, New York 13202, 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 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
October 7 ,2010

REDACTED

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

Inquiries should be directed to: Cindy M. Fascia
Associate Counsel
Bureau of Professional Medical Conduct
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF AYODEJI LUKULA, M.D.	STATEMENT OF CHARGES

AYODEJI LUKULA, M.D., Respondent, was authorized to practice medicine in New York State on or about December 8, 1993, by the issuance of license number 193051 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (for reasons of confidentiality, patients are identified only in the attached Appendix) on various occasions from on or about February 15, 2001 through on or about February 13, 2007, at Respondent's office, Cayuga Women's Health Services, then located at 143 North Street, Auburn, New York, and at Auburn Memorial Hospital. Respondent's care of Patient A did not meet accepted standards of care in that:

1. Respondent failed to maintain a medical record for Patient A in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient A.

2. Respondent, from on or about October 15, 2002 through on or about September 16, 2003 provided obstetrical care to Patient A, including pre-natal and post-partum care.

    (a) Respondent failed to adequately manage and/or to document management of Patient A's gestational diabetes.

    (b) Respondent failed to order, perform or to refer Patient A for performance of a detailed anatomic ultrasound.

(c) Respondent documented that Patient A was a Type 1-B gestational diabetic, when such a designation does not exist and/or when said designation was incorrect.

(d) Respondent failed to order adequate monitoring of Patient A's fetus during her pregnancy, including non-stress tests.

(e) Respondent inappropriately utilized "placental grading" in assessing the well-being of Patient A's fetus.

(f) Respondent, in his post-partum care of Patient A, treated her with multiple courses of antibiotics without culture or physical evidence of infection.

3. Respondent, on or about February 13, 2007, prescribed Femcon, an oral contraceptive, for Patient A's irregular vaginal bleeding.

(a) Respondent prescribed an oral contraceptive for Patient A despite the fact that Patient A was an insulin dependent diabetic and a smoker.

(b) Respondent prescribed an oral contraceptive for Patient A, who also presented with a breast lump at that office visit, without adequately evaluating Patient A's breast lump.

(c) Respondent prescribed an oral contraceptive for Patient A's irregular vaginal bleeding without adequately evaluating Patient A for the cause of said bleeding and/or without adequately evaluating Patient A for her abnormal uterine findings,

(d) Respondent prescribed an oral contraceptive for Patient A without taking and/or recording her blood pressure.

4. Respondent made or caused to be made a false entry in Patient A's medical records.

5. Respondent's medical records for Patient A are not adequately legible.

B. Respondent provided medical care to Patient B from on or about November 29, 2007, through on or about June 16, 2008, at Cayuga Women's Health Services (Respondent's office). Respondent's care of Patient B did not meet accepted standards of care, in that:

1. Respondent, after his hospital privileges at Auburn Memorial Hospital were suspended on or about April 23, 2008, continued to provide pre-natal care for Patient B without promptly notifying Patient B that he had

no hospital privileges and could not provide care to her in a hospital setting.

2. Respondent, after Patient B had transferred her prenatal care to another physician, failed to promptly make Patient B's medical record available to the subsequent treating physician, despite repeated requests and despite the fact that Patient B was near term.

3. Respondent failed to fax or otherwise timely provide a copy of Patient B's prenatal record to Auburn Memorial Hospital on or about June 16, 2008, when Respondent had advised Patient B's husband and/or Patient B that she should be brought to Auburn Memorial Hospital for evaluation.

4. Respondent failed to order or perform detailed anatomic ultrasound during the course of Patient B's pregnancy.

5. Respondent failed to maintain a medical record for Patient B in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient B.

6. Respondent's medical records for Patient B are not adequately legible.

7. Respondent, when his medical malpractice insurance had lapsed for nonpayment, and when he was practicing in violation of his Consent Order with OPMC, continued to provide prenatal care in his office to Patient B.

C. Respondent provided medical care to Patient C on various occasions from on or about March 12, 1997 through on or about April 9, 2008 at Respondent's office and at Auburn Memorial Hospital. Respondent's care of Patient C did not meet accepted standards of care, in that:

1. Respondent, on or about May 3, 2007, when Patient C presented for and/or requested screening for sexually transmitted disease, failed to adequately evaluate the patient for sexually transmitted diseases.

2. Respondent, despite Patient C's history of having previously given birth to an infant with a lethal cardiac defect, failed to adequately assess the fetal heart during Patient C's pregnancy in 2007-2008.

3. Respondent, despite Patient C's history of hypertension, failed to perform non-stress tests.

4. Respondent failed to adequately assess Patient C's history of a preterm birth.

5. Respondent failed to make a timely diagnosis of gestational diabetes in Patient C, and made a misleading and/or inaccurate entry in Patient C's hospital record regarding the management and control of Patient C's gestational diabetes.

6. Respondent, on or about March 25, 2008, admitted Patient C to Auburn Memorial Hospital for delivery.

   (a) Respondent, after making two failed attempts to perform a vacuum delivery, waited approximately 45 minutes before attempting a third time to perform a vacuum delivery of Patient C's infant.

   (b) Respondent, after making two failed attempts to perform a vacuum delivery, failed to timely perform a cesarean section.

   c) Respondent failed to adequately document his attempts to perform an operative vaginal delivery.

   (d) Respondent inaccurately and/or inadequately documented that there had been a failed attempt at a forceps delivery of Patient C's infant.

7. Respondent, on various occasions during the course of his treatment of Patient C, ordered and/or treated Patient C with antibiotics without adequate indication or evaluation and/or diagnosed Patient A with various conditions without adequate indication or evaluation.

8. Respondent failed to maintain a medical record for Patient C in accordance with accepted medical standards and/or in a manner which adequately and/or accurately reflected his care and treatment of Patient C.

9. Respondent's medical records for Patient C are not adequately legible.

D. Respondent provided medical care to Patient D, during a pregnancy with an estimated date of delivery in January 2006, at Respondent's office and at Auburn Memorial Hospital. Respondent's care of Patient D did not meet accepted standards of care in that:

   1. Respondent failed to maintain a medical record for Patient D in accordance with accepted medical standards and/or in a manner which adequately reflected his care and treatment of Patient D.

   2. Respondent failed to adequately monitor or respond to Patient D's blood glucose levels during the pregnancy.

   3. Respondent failed to adequately instruct Patient D concerning glucose monitoring.

4. Respondent failed to take adequate steps to attempt control of Patient D's blood sugar or to seek appropriate consultation.

5. Respondent diagnosed Patient D as having gestational diabetes when she had been diagnosed as diabetic before the pregnancy.

6. Respondent planned a glucose challenge test for Patient D, a known diabetic.

7. Respondent failed to order or perform detailed anatomic ultrasound during the course of Patient D's pregnancy.

8. Respondent, on various occasions, diagnosed Patient D as having urinary tract infection, cystitis, and vaginosis without adequate evaluation or cultures.

9. Respondent ordered antibiotics for Patient D's diagnoses of urinary tract infections, or cystitis, or rash without adequate indication.

10. Respondent failed to document his plan or rationale to induce labor in December 2005.

11. Respondent did not adequately document in Patient D's hospital record why Patient D was admitted to the hospital in December 2005 or the status of the patient at that time.

12. Respondent admitted Patient D to the hospital for induction without adequate indication and/or without documentation of assessment of fetal lung maturity.

13. Respondent's medical records for Patient D are not adequately legible.

E. Respondent treated Patient E from approximately 2004 to 2006, at Respondent's office and at Auburn Memorial Hospital. Respondent's care of Patient E did not meet accepted standards of care in that:

1. Respondent inappropriately or inaccurately diagnosed Patient E with menorrhagia when the correct diagnosis was metrorrhagia.

2. Respondent, following his performance of a hysteroscopy in 2004, inappropriately or inaccurately diagnosed Patient E as having an enlarged uterus with a submucous fibroid.

3. Respondent inappropriately or inaccurately interpreted an ultrasound in 2006 as showing bilateral ovarian cysts.

4. Respondent did not adequately document his rationale or discussions with Patient E, who was pre-menopausal, for removal of both her ovaries.

5. Respondent, on or around May 12, 2006, planned to perform a hysterectomy and bilateral salpingo-oophorectomy on

Patient E without adequate indication.

6. Respondent, on or around May 12, 2006, planned to perform a hysterectomy and bilateral salpingo-oophorectomy on Patient E without adequate informed patient consent.

7. Respondent, after an operation on May 12, 2006, inappropriately or inaccurately described in his operative note that Patient E 's uterus was 8 weeks size.

8. Respondent, after an operation on May 12, 2006, inappropriately or inaccurately diagnosed Patient E as having endometriosis.

9. Respondent, on or about May 12, 2006, removed a normal ovary from Patient E without adequate indication.

10. Respondent's operative note of May 12, 2006, is not sufficiently understandable to describe the surgery he performed or his decision-making process during surgery.

11. Respondent's records for Patient E are not adequately legible.

12. Respondent failed to maintain a medical record for Patient E that was in accordance with accepted medical standards and/or in a manner which accurately reflected his care and treatment of Patient E.

F. Respondent treated Patient F from approximately 1996 until approximately 2004, at his office and at Auburn Memorial Hospital. Respondent's care of Patient F did not meet accepted standards of care in that:

1. Respondent diagnosed Patient F as having vaginosis and treated her for vaginosis without adequate evaluation and diagnostic testing.

2. Respondent diagnosed and treated Patient F as having chlamydia, a sexually transmitted disease, without adequate evaluation and cultures.

3. Respondent diagnosed Patient F as having uterine fibroids after a sonogram performed on Patient F noted "no fibroid".

4. Respondent admitted Patient F to Auburn Memorial Hospital on or about August 15, 1997 for a LAVH (laparoscopic assisted vaginal hysterectomy). Respondent's admitting note stated that the patient had "large uterine fibroids, about 15 week size", or words to such effect, without adequate basis.

5. Respondent failed to perform adequate endometrial evaluation of Patient F before the surgery of August 15, 1997.

6. Respondent made preoperative diagnoses for Patient F of menorrhagia, an enlarged uterus and barrel shaped cervix, yet failed to obtain adequate evaluation of Patient F prior to surgery.

7. Respondent, in his operative note for Patient F, reported finding a uterus with multi-nodular fibroid and adenomyosis, when there was neither.

8. Respondent's operative note of August 15, 1997, is not sufficiently understandable to describe Respondent's surgery on Patient F or his decision-making during surgery.

9. Respondent performed inadequate surgery on August 15, 1997, and/or failed to refer Patient F for definitive surgery after the diagnosis of cancer was made.

10. Respondent failed to provide, refer or otherwise assure adequate followup or a treatment plan for the reported moderate to well-differentiated adenocarcinoma in Patient F's uterus, extending into the endocervical canal and fallopian tube.

11. Respondent failed to adequately or accurately discuss or document his discussion with Patient F concerning the cancer findings and appropriate options for treatment after the August 1997 surgery.

12. Respondent failed to refer Patient F in January 1998 when he documented and/or expressed concern in her medical record of possible recurrent cancer.

13. Respondent failed to inform or to document informing other subsequent treating physicians of Patient F's history of cancer.

14. Respondent diagnosed Patient F as having urinary tract infection, yeast infection, and mixed monilial discharge and treated her with medications without adequate evaluation or cultures.

15. Respondent, after the August 15, 1997 surgery and subsequent pathology reports, signed documents stating Patient F had a fibroid uterus when he knew or should have known that diagnosis was inaccurate.

16. Respondent failed to maintain a medical record for Patient F that was in accordance with accepted medical standards and/or in a manner which accurately reflected his care and treatment of Patient F.

G. Respondent treated Patient G from approximately 2002 to approximately 2006, including during a pregnancy with an estimated due date in April 2006, at his office and at Auburn Memorial Hospital. Respondent's care of Patient G did not meet accepted standards of care in that:

1. Respondent's records for Patient G are not adequately legible.

2. Respondent failed to take adequate histories during the pregnancy concerning Patient G's drug, alcohol, and tobacco use.

3. Respondent failed to obtain adequate fetal assessment despite his documentation that Patient G was a drug abuser with a history of tobacco use.

4. Respondent failed to obtain adequate anatomic fetal ultrasound assessment.

5. Respondent failed to timely administer Rhogam to Patient G and/or to document timely administration.

6. Respondent failed to maintain a medical record for Patient G in accordance with accepted medical standards and/or in a manner which accurately reflects his care and treatment of Patient G.

H. Respondent entered into a Consent Order, BPMC Order No. 05-172 (hereafter BPMC No. 05-172), which Order became effective on or about August 16, 2005. Respondent, under the terms of BPMC No. 05-172, was subject to certain conditions, and a three year period of probation.

1. Respondent, pursuant to Paragraph/Probation Term 9 (e) of BPMC No. 05-172, was ordered to maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230 (18) (b) of the Public Health Law. Respondent, while the terms of probation and conditions of BPMC No. 05-172 were in effect, and/or while Respondent was engaged in the practice of medicine in New York State, failed to maintain the required medical malpractice coverage.

2. Respondent, pursuant to Paragraph/Probation Term 7 of BPMC No. 05-172, was required to maintain complete and legible medical records that accurately reflect his evaluation, treatment and plan for patients. Respondent, while the terms of probation and conditions of BPMC No. 05-172 were in effect, failed to maintain medical records which met the requirements of this term of probation.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of New York Education Law § 6530(3) in that Petitioner charges two or more of the following:

1. The facts of paragraphs A, B, C, D, E, F, and/or G, and any or all subparagraphs.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing with incompetence on more than one occasion within the meaning of New York Education Law § 6530(5) in that the Petitioner charges two or more of the following:

2. The facts of paragraphs A, B, C, D, E, F, and/or G, and any or all subparagraphs.

THIRD THROUGH NINTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of New York Education Law § 6530(4) in that Petitioner charges:

3. The facts of paragraph A and any or all of the following subparagraphs: A.1, A.2 and A.2(a), A.2(b), A.2(c), A.2(d), A.2(e) and A.2(f), A.3 and A.3(a), A.3(b), A.3(c) and A.3(d).

4. The facts of paragraph B and any or all of the following subparagraphs: B.1, B.2, B.3, B.4, B.5, B.6 and B.7.

5. The facts of paragraph C and any or all of the following subparagraphs: C.1, C.2, C.3, C.4, C.5, C.6 and C.6(a), C.6(b), C.6(c), C.6(d), C.7, C.8 and C.9.

6. The facts of paragraph D and any or all of the following subparagraphs: D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12 and D.13.

7. The facts of paragraph E and any or all of the following subparagraphs: E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11 and E.12.

8. The facts of paragraph F and any or all of the following subparagraphs: F.1, F.2, F.3, F.4, F.5, F.6, F.7, F.8, F.9, F.10, F.11, F.12, F.13, F.14, F.15, and/or F.16.

9. The facts of paragraph G and any or all of the following subparagraphs: G.1, G.2, G.3, G.4, G.5 and/or G.6.

TENTH THROUGH SIXTEENTH SPECIFICATIONS
PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence within the meaning of New York Education Law § 6530(6) in that Petitioner charges:

10. The facts of paragraph A and any or all of the following subparagraphs: A.1, A.2 and A.2(a), A.2(b), A.2(c), A.2(d), A.2(e) and A.2(f), A.3 and A.3(a), A.3(b), A.3(c) and A.3(d).

11. The facts of paragraph B and any or all of the following subparagraphs: B.1, B.2, B.3, B.4, B.5, B.6 and B.7.

12. The facts of paragraph C and any or all of the following subparagraphs: C.1, C.2, C.3, C.4, C.5, C.6 and C.6(a), C.6(b), C.6(c), C.6(d), C.7, C.8 and C.9.

13. The facts of paragraph D and any or all of the following subparagraphs: D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12 and D.13.

14. The facts of paragraph E and any or all of the following subparagraphs: E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9, E.10, E.11 and E.12.

15. The facts of paragraph F and any or all of the following subparagraphs: F.1, F.2, F.3, F.4, F.5, F.6, F.7, F.8, F.9, F.10, F.11, F.12, F.13, F.14, F.15, and/or F.16.

16. The facts of paragraph G and any or all of the following subparagraphs: G.1, G.2, G.3, G.4, G.5, and/or G.6.

SEVENTEETH AND EIGHTEENTH SPECIFICATIONS
VIOLATING ANY TERM OF PROBATION OR CONDITION OR LIMITATION

Respondent is charged with violating a term of probation or condition or limitation imposed on him pursuant to section two hundred thirty of the public health law, in violation of New York Education Law § 6530 (29), in that Petitioner charges:

17. The facts in Paragraphs H and H.1.

18. The facts in Paragraphs I and I.2, and any of the following: A.1, A. 2(a), A.2(c), A.4, A.5, B.5, B.6, C.5, C.6(c), C.6(d), C.8, C.9, D.1, D.10, D. 11, D.12, D.13, E.4, E.7, E.10, E:11, G.1, G.5, and G.6.

NINETEENTH THROUGH TWENTY-FIFTH SPECIFICATIONS
FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of New York Education Law § 6530 (32), in that Petitioner charges:

19. The facts in Paragraphs A and A.1 and/or A.2(a) and/or A.4.

20. The facts in Paragraphs B and B.5.

21. The facts in Paragraphs C and C.5 and/or C.6(c) and/or C.6(d) and/or C.8.

22. The facts in Paragraphs D and D.1 and/or D.10 and/or D.11 and/or D.12.

23. The facts in Paragraphs E and E.4 and/or E.7 and/or E.10 and/or E.12.

24. The facts in Paragraphs F and F.4 and/or F.7 and/or F.8 and/or F.11 and/or F.13 and/or F.15 and/or F.16.

25. The facts in Paragraphs G and G.5 and/or G.6.

TWENTY-SIXTH SPECIFICATION
FRAUDULENT PRACTICE

Respondent is charged with practicing medicine fraudulently within the meaning of New York Education Law § 6530(2), in that Petitioner charges:

26. The facts in Paragraphs A and A.4.

TWENTY-SEVENTH SPECIFICATION
MAKING OR FILING A FALSE REPORT

Respondent is charged with wilfully making or filing a false report, in violation of New York Education Law § 6530(21), in that Petitioner charges:

27. The facts in Paragraphs F and F.15.

Dated: October 7, 2010
Albany, New York

REDACTED

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