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NEW YORK
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HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 3, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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RE: In the Matter of Ifechukwude Ojugbeli, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-17) 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., Chief 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
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
IFECHUKWUDE OJUGBELI, M.D.	:	ORDER
		BPMC #12-17

A Notice of Hearing and Statement of Charges, both dated April 28, 2011, were served upon the Respondent, Ifechukwude Ojugbeli, M.D. **PETER KANE, M.D.**, Chairperson, **ANDREW MERRITT, M.D.** and **VIRGINIA MARTY**, 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, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health ("the Department") appeared by **JAMES E. DERING**, General Counsel, by **MICHAEL A. HISER, ESQ.**, of Counsel. The Respondent appeared by SMITH, SOVIK, KENDRICK & SUGNET, P.C., **MICHAEL PAUL RINGWOOD, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	April 28, 2011
Answer Filed:	May 23, 2011
Pre-Hearing Conference:	June 1, 2011
Hearing Dates:	June 10, 2011 August 4, 2011 August 12, 2011 October 7, 2011
Witnesses for Petitioner:	Arup De, M.D. Brett Shulman, M.D. Patient A Patient A's spouse Patient C Patient E
Witnesses for Respondent:	Ifechukwude Ojugbeli, M.D. Sheila Aylesworth, L.P.N. Frederic Joyce, M.D.
Deliberations:	December 7, 2011

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

This 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.

Ifechukwude Ojugbeli, M.D. ("Respondent") is charged with twenty-two specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"), relating to Respondent's medical care of nine patients. The charges as amended include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, performing services not duly authorized, and failure to maintain records. A copy of the Notice of Hearing and 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. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

1. IFECHUKWUDE OJUGBELI, M.D., the Respondent, was authorized to practice medicine in New York State on March 12, 1998, by the issuance of license number 209777 by the New York State Education Department (Stipulated fact at pre-hearing, T. 9).

2. Conscious sedation is a technique of anesthesiology that is not only done by anesthesiologists; it can be used by anyone with sufficient medical training (T. 139).

3. Conscious sedation falls under the spectrum of anesthesia where the administration of medication allows patients to breathe on their own and remain reasonably aware of their surroundings. The expectation is that they maintain their airway and hemodynamics (T. 138).

4. When administering conscious sedation, the patient should be assessed with a focused history. The medical history would include a systemic approach to past medical illnesses, the presence or absence of cardiac disease or pulmonary disease, any kind of hepatic or renal insufficiency and a prior surgical history. The reasonably prudent physician would inquire about the patient's daily medications, allergies and sensitivities. The physician would also ascertain when the patient last ate or drank, especially since the medications given can depress airway reflexes or oropharyngeal reflexes, which are the protective reflexes for swallowing/breathing (T. 142-44).

5. With conscious sedation, patients react to medications in

unique ways, so administering a specific dose of medication to a patient may push them farther along the spectrum of anesthesia than another patient (T. 138).

6. Obtaining medical history information helps to determine what types and amounts of anesthetic to give a patient. Medications are broken down and processed in the body through very specific pathways. Since some involve the liver, hepatic function is critical. Some involve the kidneys, so renal function and excretion of the compounds and metabolites is critical. Trivial amount of medication for one person could in fact be an astronomical amount of medication for a person with impaired liver of hepatic function. Even in seemingly small doses, medications can accumulate in the body and have unintended consequences (T. 145).

7. The guidelines for performing conscious sedation involve appropriate monitoring, assessment and evaluation of a patient to determine whether they are an acceptable candidate for conscious sedation. Once a decision is made to proceed, consent is obtained, and appropriate monitors placed. The patient is then monitored during the procedure and afterwards (T. 140).

8. It is not uncommon for a patient who has been administered medications used during conscious sedation to forget events immediately preceding and for several hours after the procedure (T. 162).

9. These medications individually and in concert can work to depress respirations. They can also work to depress oropharyngeal reflexes that are protective in terms of passive reflux of gastric contents into the lungs. Having such gastric contents in the lungs can lead to a life-threatening pneumonitis, if not death (T. 144-145).

10. If the physician fails to obtain the necessary medical history, there is a risk of administering a dosage of medicine that would have unintended consequences (T. 149).

11. If a physician allows a patient to document their own medical history, the physician should interpret the history in his own record (T. 710).

12. A reasonably prudent physician would sign a note indicating they had reviewed a history that was taken of a patient (T. 184-185).

13. Prior to performing conscious sedation, a reasonably prudent physician would conduct at a minimum the assessment of a patient's airway, height and weight in terms of determining overall body habitus (T. 150).

14. Assessing the airway gives an indicator as to the level of difficulty that the physician may have supporting the airway if the patient's respiratory drive is diminished or they obstruct their airway (T. 151).

15. In addition, the patient should have a basic heart and lung

exam involving listening with a stethoscope for a regular heart rhythm, heart sounds, the presence or absence of rubs, or other heart sounds or irregularity. The lungs should also be listened to, to make sure they are clear and there is no wheezing (T. 152).

16. There are risks to the patient if the physical exam as indicated is not done. A patient with an unanticipated difficult airway who is not assessed may not be an appropriate candidate for an outpatient setting. A patient who has a bradycardia or tachycardia can have a poor outcome, even if they appear healthy (T. 153-154).

17. If a heart and lung exam is done before the sedation, but not documented, a reasonably prudent physician would not consider the documentation to be complete (T. 712).

18. The physical examination should include vital signs for a patient undergoing sedation (T. 711).

19. Documentation has a role in the monitoring that should have been performed. It provides a real time record of the patient's physiologic state during all parts of the procedure, showing whether the blood pressure was stable, the heart rate was stable, and the oxygen saturation was appropriate. It gives an overall indicator of the stability of the patient as he or she undergoes a procedure (T. 163).

20. A reasonably prudent physician would make a record of the procedure so that, on review by a subsequent observer, there would be

an accurate and reproducible way of understanding what occurred (T. 263).

21. This information is necessary because patients go from physician to physician. Any future procedures or choices in medical care must take into account past medical history (T. 263-264).

22. There are risks to a patient when a physician fails to document the procedure. An adage is that if "you don't write it down, it didn't happen." Here Respondent failed to create a medical record that can be used by the medical community to understand what was done. There may be procedures that Patient A may have in the future where the changes that occurred in anatomy during a prior surgery that were not documented may ultimately end up resulting in some morbidity (T. 265).

23. Monitoring should be done on a patient under conscious sedation to assess physiologic systems in the body. The cardiovascular system should be monitored as well as heart rate and blood pressure, and ventilation and oxygenation. The minimum standard requires a blood pressure cuff and a pulse oxymeter throughout the procedure (T. 158).

24. Monitoring during the procedure with EKG leads is not required to meet the minimum standard of monitoring (T. 684-685).

25. Even in a procedure that is expected to last 15 minutes or less, the requirement for monitoring and pre-surgical or post-

surgical evaluations remains. This is because the risks of the anesthetic are inherent to the anesthetic, not the duration of the procedure (T. 186).

26. Informed consent is a frank discussion of the risks and benefits with the patient so that he or she is aware of all possible outcomes before they go ahead and give the physician permission to proceed (T. 163).

27. A reasonably prudent physician should provide certain information to a patient before they undergo conscious sedation. The delineation of risks needs to be clear so that the patient knows the possible unique and untoward reactions to medications, airway compromise, maintenance of the airway, as specific interventions that may or may not be taken to assist the patient in those situations (T. 164).

Patient A

28. Respondent treated Patient A from approximately June 2005 to September 2007, at Visage Medical Aesthetics, 3709 Erie Blvd., Dewitt, N.Y. ("Respondent's Visage Office") (Ex. 3; T. 100).

29. Respondent performed procedures including a thread lift on Friday, May 26, 2006. A thread lift is a procedure in which a barbed suture is placed within the face to lift the supporting tissues and hold them in place (Ex. 3; T. 100, 261).

30. Respondent performed conscious sedation on Patient A during

the May 26, 2006 procedure. Respondent administered Versed or Midazolam which is a Benzodiazepine, and Demerol which is an Opioid (Ex. 3, p. 12; T. 141-142).

31. Respondent failed to obtain and/or document an adequate history prior to performing the surgical procedure on the patient using conscious sedation in May 26, 2006 (Ex. 3).

32. Information obtained for the medical history should be documented. Appropriate documentation reflects the performance of the procedure, whether it is the history or the physical exam for the procedure performed. Respondent's medical history for Patient A is contrary to what a reasonably prudent physician would have obtained (T. 149).

33. Information related to the cardiovascular, respiratory, hepatic, renal function and alcohol consumption is not present. There is also no information documented regarding personal habits regarding alcohol/drug use (T. 148, 185).

34. Respondent's medical record for Patient A does not contain the information that should be obtained in a medical history before doing this procedure (T. 148).

35. Respondent did not assess Patient A with a focused physical exam (T. 142-143).

36. Respondent's medical record for Patient A does not contain an evaluation that a reasonably prudent physician would have

conducted prior to the conscious sedation done on this patient (T. 152-153).

37. There is no documentation in Patient A's chart of a physical exam other than a dermatologic or aesthetic exam (T. 185).

38. Respondent performed this procedure with a nurse present. He remained ultimately responsible in that setting for the physical well-being of the patient (Ex. 3, p. 12; T. 143).

39. Patient A received several medications during the conscious sedation on May 26, 2006. One was Midazolam, which has trade name of Versed. Midazolam is short acting Benzodiazepine. It is considered a shorter acting version of Diazepam or Valium. Its main use in this setting is as an anxiolytic and as an amnestic prior to the commencement of an interventional procedure (T. 154).

40. The amount of Versed used was 2.5 mg given intravenously (Ex. 3, p. 12).

41. There is a risk of a possible allergic reaction in giving Versed to a patient (T. 156-157).

42. Patient A was also given Demerol. Demerol is an opioid, meaning it is used to treat and relieve pain. The amount of Demerol used in this case was 50 mg. (Ex. 3, p. 12; T.156).

43. There are risks associated with using Demerol because it is an opioid. Demerol itself can cause some transient increases in heart rate. It also depresses airway reflexes and shifts the airway

response. In other words, the patient forgets to breath or breathes less often (T. 157-158).

44. The operative note does not indicate whether any monitors were placed (Ex. 3, p. 12; T. 158).

45. There are no vital signs in the chart. If monitoring was done by a machine, even one that did not have a recorder, it is the responsibility of the performing surgeon to document the presence or absence of a monitor (T. 185).

46. Patient A drove to the Erie Boulevard office to have the procedure on May 26, 2006, and drove home afterwards (T. 98-99).

47. It was unsafe for the patient to drive a car or operate any kind of heavy machinery after having these medications administered. There is no specific comment in the patient record about the patient's state of alertness after the procedure (Ex. 3, p. 12; T. 159-160).

48. A patient who has had conscious sedation cannot assess their own ability to drive or their own alertness after a procedure (T. 184).

49. It is the standard of care for a reasonably prudent physician to document the alertness of a patient and a set of vital signs that show that the patient is back to baseline or their normal levels (T. 184).

50. Respondent failed to adequately document Patient A's vital

signs, cardiac activity and oxygen saturation during the period of anesthesia during the conscious sedation procedure as a reasonably prudent physician would have done (T. 160).

51. The risks to a patient who is not properly monitored are varied, given these medications in concert. In the absence of monitors, the physician may not know that he needs to take appropriate interventions (T. 161).

52. After the May 26, 2006 procedure, Patient A was unhappy with the result. Her left cheek had sunken in, and she felt something was really wrong (T. 101-102, 118-120).

53. Based on those concerns, Patient A contacted Respondent and told him that the result was unsatisfactory (T. 104).

54. As a result of that conversation, Patient A was told to come to his office in Chittenango where he would correct it (T. 105).

55. Patient A went to the Chittenango office on a Sunday, approximately a week after the May 26. 2006 procedure. She was accompanied by her husband who drove (T. 105-107, 113, 117. 118-120).

56. She initially went into the office, and her husband waited outside. A corrective procedure was done while Patient A was under anesthesia (T. 106-07, 115, 161-162).

57. The monitoring requirements for this procedure under conscious sedation were the same as the first (T. 162).

58. Respondent failed to adequately document the additional

procedure which he performed on Patient A (T. 264).

Patient B

59. Respondent treated Patient B from on or about April 2006 to May 2006, at Respondent's Visage Office. Respondent performed a thread lift on or about May 22, 2006, using conscious sedation (Ex. 5, p. 3; T. 189).

60. The history documented for the patient is a handwritten note. No significant past medical history is related. The notation "past medical history non-contributory" does not tell very much about a patient's medical history. Not even the patient's age is in the record (Ex. 5, p. 5; T. 190-191).

61. Patient B was in his late 60's. It would be medically significant if the patient was in his late 60's at the time of the procedure. Men in their late 60's are at risk for cardiac disease and pulmonary disease which is significant for a patient undergoing conscious sedation. The stress of surgery in terms of anticipation, overall anxiety and level of stress can be significant (T. 191-192, 603).

62. Respondent did not document any social history questions for Patient B. Obtaining such questions would also be important (T. 208-209).

63. Respondent's documented history for the patient is inconsistent with the history a reasonably prudent physician would

have taken (T. 192).

64. The physical examination that is documented in the record is listed as a "cosmetic exam." There is no examination in terms of airway assessment, cardiac examination, blood pressure or heart rate (Ex. 5, p. 5; T. 193).

65. Respondent's documented medical exam for Patient B is inconsistent with what a reasonably prudent physician would have done. A reasonably prudent physician would have documented a more extensive exam and history (T. 193-194).

66. This patient has a listing of vital signs reflected on page six. The listing contains only part of the minimally indicated monitoring. The parts that are reflected there are a blood pressure and a heart rate; however, the level of oxygenation as described by a pulse oxymeter is not documented or listed (Ex. 5; T. 194).

67. During the procedure, the patient's blood pressure appears to be hypertensive on numerous occasions. Since there was no baseline blood pressure, the treatment indicated is unclear. There is a difference in treatment as to the blood pressure level within the procedure intra-operatively depending upon the starting blood pressure. This patient underwent a procedure according to the vital signs sheet of approximately two hours (Ex. 5, p. 6.; T. 209).

68. A reasonably prudent physician would ascertain the blood pressure pre-operatively (T. 210).

69. Respondent did not appropriately document the patient's vital signs during the conscious sedation procedure because the pulse oxymeter and heart rhythm were not documented (T. 195-196).

70. Respondent discussed the risks and benefits of the procedure with Patient B (Ex. 5, p. 5).

Patient C

71. Respondent treated Patient C from on or about September 2005 to July 2006, at Respondent's Visage Office (Ex. 6).

72. Patient C recalled her meeting with Respondent. She saw an ad in the paper that indicated she could get some free laser treatment. She went to Visage to have that treatment in September 2005 (Ex. 6, pp. 3-5; T. 62).

73. Respondent obtained and documented some information from the patient as a medical history. The information was obtained at the patient's first visit on September 10, 2005 (Ex. 6, pp. 3-4, 14).

74. Approximately 13 months before in July 2004, Patient C experienced a serious medical condition known as a sub-arachnoid hemorrhage on the left side of her head. Patient C was taken to an emergency room where a CT scan showed layered left front frontal inter-cranial hemorrhage. Patient C was admitted to the hospital on July 27, 2004, and was in a coma for approximately three weeks. She was discharged from the hospital to a rehabilitation facility for further speech and movement therapy (Ex. 7, pp. 3, 8; T. 65-66).

75. The patient had a very eventful medical history the year before she saw Respondent in September 2005. She was admitted as an inpatient for almost a full month, spent a fair amount of time in the ICU, and had multiple invasive procedures (Ex. 7; T. 215-216).

76. In September 2005, Patient C was on Dilantin related to the July 2004 event. She had never taken Dilantin prior to her medical events in July 2004 (T. 66, 89).

77. Dilantin is normally given to prevent seizures, but it is also given for an intracranial cerebral mass, epilepsy, or prior surgery. A patient on Dilantin may also require potentially greater doses of medicine, depending on the level of Dilantin (T. 214-215).

78. Respondent's documented medical history for Patient C contains some of the information that a reasonably prudent physician would want to obtain from a patient, but it is not complete. For example, the medications Synthroid and Dilantin are listed, but no medical indication explaining why the patient is taking these medications is documented. Although it can be supposed that the patient is taking Synthroid for hypothyroidism, there is no indication as to why the patient is taking Dilantin. A reasonably prudent practitioner would ascertain why a patient is on Dilantin (Ex. 6, p.4; T. 213-214, 226).

79. Respondent does not document any of this medical history in his chart. The medical history documented by Respondent is

inconsistent and incomplete (T. 217).

80. Given this patient's particular medical history, a fairly thorough physical examination should have been undertaken. This patient had a cerebral vascular disease. That is a systemic process with quite likely similar plaques and concern for the cardiac system, for the renal system, and for the overall vascular system. Her past medical history may also represent an increased aspiration risk with small amounts of medicine. Therefore, a further evaluation of her swallowing or breathing was required (T. 218-19).

81. Respondent's documented physical exam of Patient C is inconsistent with what a reasonably prudent physician would have documented (T. 219-220).

82. In September and November 2005, Respondent performed thread lifts on Patient C (Ex. 6, p. 17; T. 64).

83. Patient C also had a thread lift done by Respondent at Visage while under anesthesia on May 20, 2006 (Ex. 6, pp. 8-9).

84. Patient C drove to the Visage location and home after the procedure on May 20, 2006 (T. 70).

85. The surgical procedure where Patient C received medication was done on Erie Boulevard. The total time that she was in the office for the thread lift was approximately 2:00 to 5:30 p.m. (T. 85-86).

86. Patient C was allowed to leave the facility about one hour after the procedure. Patient C remembers driving home (T. 85-86).

87. Neither Respondent nor any other member of his staff documented any monitoring of the patient or any specific vital signs before, during, or after the procedure. No blood pressures, oxygenation via pulse oximetry or respirations were documented (Ex. 6).

88. Respondent, during the thread lift procedures performed under conscious sedation on or about May 20, 2006, failed to adequately document vital signs, cardiac activity, oxygen saturation and the period of anesthesia (T. 221).

Patient D

89. Respondent treated Patient D from on or about March 2006 to January 2008, at Respondent's Visage Office. Respondent performed procedures using conscious sedation including a thread lifts on or about March 20, 2006, on or about April 10, 2006, and on or about June 9, 2006 (Ex. 8; T. 230-31, 629-30, 637-9).

90. Respondent obtained and documented some information from the patient as a medical history during the first visit on March 18, 2006 (Ex. 8, pp. 4-5, 18).

91. Respondent's medical history for this patient is contrary to what a reasonably prudent physician would have obtained and documented for the patient (Ex. 8, pp. 4-5, 18; T. 233).

92. Respondent obtained and documented some information from the patient related to a physical examination at the patient's first

visit on March 18, 2006 (Ex. 8, pp. 4-5, 18).

93. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing surgical procedures on the patient using conscious sedation (T. 233-234).

94. If there had been conscious sedation procedures done previously, the physician should document the patient's prior experience in some fashion (T. 712-713).

95. Respondent performed a contour thread lift on the mid face of this patient on March 20, 2006. Neither Respondent nor any other member of his staff documented any monitoring or any specific vital signs before, during, or after the procedure. Blood pressures, oxygenation via pulse oximetry and respirations were not documented. A reasonably prudent physician would have documented monitoring of these vital signs (Ex. 8, p. 22; T. 234-235).

96. Respondent performed a revised contour thread lift on or about April 10, 2006. While the procedure is only referenced in his medical record by inference, Respondent admitted that he must have performed this second procedure, and that it must have been done under conscious sedation (Ex. 8, pp. 14, 24; T. 637-9).

97. Respondent failed to adequately document vital signs, cardiac activity, oxygen saturation, and the period of anesthesia. This vital signs listing contains only part of the minimally indicated monitoring. A blood pressure and a heart rate are recorded;

however, the cardiac rhythm, and the level of oxygenation as described by a pulse oxymeter are not documented or listed (Ex. 8, p. 24; T. 194 as discussed re Patient B).

98. Thereafter, the patient came back in on April 10 for a revised contour thread lift. During that procedure, the patient was monitored for blood pressure and heart rate (Ex. 8, pp. 14, 24; T. 637-639).

99. Respondent failed to adequately document the procedure performed on or about April 10, 2006. Also, there is no monitoring on the strip that there was evidence of any oxygen saturation monitoring (T. 303).

100. Neither Respondent nor any other member of his staff documented any monitoring of the patient, or any specific vital signs before, during, or after the procedure on June 9, 2006. No blood pressures, oxygenation via pulse oximetry, or respirations were documented (Ex. 8; T. 236).

101. The patient was being treated with Xanax as of October 2005, six months before she came into treatment with Respondent. She had in fact been on Xanax for many years. After the procedure of June 9, 2006 performed by Respondent, the patient became anxious. Respondent then gave her 20 tabs of Xanax for anxiety (Ex. 8, pp. 19-20).

102. Respondent provided Xanax to this patient on four other

occasions (August 22, September 14, October 19, and January 11). During this time, the patient was still receiving Xanax from her primary care physician (Ex. 8, pp. 26, 33-35, Ex. 26, pp. 2, 5, 7, 9 12).

103. There can be contraindications to giving Xanax to a patient. Xanax is a central nervous system depressant. It can interact with other sedating medications. Xanax also has abuse potential. Given its abuse potential, it would have been prudent to either communicate with her primary care physician or refer the patient back for her prescriptions (T. 305-306).

104. There is no indication in the record that Respondent communicated with the other physician (Ex. 8, 26).

105. Respondent's prescription of Xanax on multiple occasions despite the fact she was being treated by another physician, without informing the other physician of his treatment, and/or documenting that he informed the other physician of his prescribing Xanax was contrary to what a reasonably prudent physician would have done (T. 307).

Patient E

106. Respondent treated Patient E from on or about May through June 2006, at Respondent's Visage Office. Patient E first contacted the office through the internet. Respondent's office was running a special. She first saw the Respondent in May 2006 at his Visage

office on Erie Boulevard East for sclerotherapy (Ex. 10, pp. 2-3; T. 26-27).

107. Patient E had prior experience with sclerotherapy. She had had it done in 1993 and had no problems. On May 17, 2006, when she went to Visage and saw Respondent, the substance of the conversation was that her treatments would take more than one visit. Respondent recommended laser treatment and sclerotherapy (Ex. 10, p. 7).

108. Patient E gave a medical history of spider veins. Spider veins are another name for telangiectasias. These are poor, dilated vessels that by convention have been defined as 1 mm in size or smaller. The medical significance of spider veins is that they are known ectatic vessels; they are abnormal. These vessels usually come as a result of some defect in the ectatic venous system. They are usually found as well in the lower extremities (T. 312).

109. They are treated in generally two ways. One is the injection of sclerotherapy, and another is light-based sources. They are treated more as a cosmetic issue (T. 312-313).

110. In Respondent's initial evaluation in the record, Respondent documented that the patient's legs were "loaded with" vessels. This does not say the size of the vessels or map out their distribution; however, some photographs partially do that (Ex. 10, pp. 7-9; T. 313).

111. The photographs show the spider veins and also reticular

veins, which are the vessels that have a bluish quality to them. They are also called venulectasias (Ex. 10, p. 8-9; T. 314).

112. In treating venous disease of the ectatic leg, the physician seeks to find the highest point of reflux, in other words, the prime anatomical defect. Everything else downstream of that vessel is just the result of that point of reflux. In layman's terms, a vein is a low pressure, one way flow that has valves. As the muscles contract, blood is pushed through the valve and the valve leaflets open and then as gravity pushes back and the hydrostatic force is increased, the valve leafs close (T. 315).

113. When you have varicosities, the downstream result is that either the leaflets do not match perfectly or the valves are totally destroyed. At that point, there is a two-way flow in the vein so you have higher resting pressures below than you would have if the valve had been intact and in place. The point of reflux is the most proximal point where the vessel is not functioning properly. Those are usually fairly large caliber vessels. They are also usually either tributaries of or branch points off of the greater saphenous or the lesser saphenous veins (T. 315-316).

114. To perform sclerotherapy, the physician seeks the larger size or larger caliber vessels where he would insert a small gauge needle and inject a chemical substance, a sclerosant. This causes the vessel hopefully to shrink down either to fibrose or the lumen to be

narrowed (T. 319).

115. The sclerosant acts to damage the wall lining to ultimately reduce flow or eliminate flow. It also destroys the vein. That is the overall goal. Then the vein can recannulize and open again (T. 320).

116. Prior to a physician taking the step of injecting the patient, the medical history that a reasonably prudent physician would obtain and document from a prospective patient would be designed to make certain that the indications for treatment are appropriate. The physician should ascertain whether the patient had any procedure in the past that would alter venous anatomy. A physician would also find out whether the patient is on any medications that would increase the risk of developing a blood clot. A physician would further make sure that there are no medical contraindications to the procedure (T. 320-321).

117. The medical history obtained and documented by Respondent for Patient E is minimally consistent with what a reasonably prudent physician would have obtained (T. 322-323).

118. A physical examination should be performed prior to the performance of sclerotherapy. A reasonably prudent physician would seek a clear demarcation of the nature of the venous disease (T. 324).

119. Respondent's documented physical exam for this patient

included pre-procedure photographs and charting with color characterization of the veins to indicate size differential (Ex. 10).

120. Sodium morrhuate is a derivative of cod liver oil and its role is to act as a detergent. It renatures the lining of the blood vessels and causes a plugging of flow (T. 329).

121. Sodium morrhuate is a "grandfathered" sclerosant. Grandfathered means that it is basically a sclerosant that has been used in the United States since the mid-1930s (T. 328-329).

122. Sodium morrhuate is an FDA approved sclerosant though there are other sclerosants that offer a more favorable risk/benefit profile (T. 329).

123. The use of sodium morrhuate for sclerotherapy does not deviate from the minimally accepted standard of care (T. 678).

124. Patient E went on to have sclerotherapy injections on May 17, 2006. On the first day, her treatment was only on the right leg (Ex. 10, p. 6; T. 32-33).

125. Respondent's documentation of the May 17, 2006 procedure provides some information about what was injected, but a reasonably prudent physician would have documented the agent, the concentration of the agent that was used, the location that it was injected, and the post treatment care (T. 333; Ex 10, p. 6).

126. Respondent's documentation of the concentration of the agent is unclear. It is significant to know the concentration of the

agent because the amount of damage that is done is directly proportional to the concentration of the agent (T. 333-334).

127. A reasonably prudent physician would have documented the location of the injection (T. 334-335).

128. Respondent's documented procedure note of May 17, 2006 is not consistent with what a reasonably prudent physician would have done (T. 335).

129. Patient E went back to see Respondent for further treatment on June 1, 2006. She had laser treatment on both legs and sclerotherapy injections in both legs. Respondent wrapped her leg and told her not to take off the wrapping for five days (Ex. 10, p. 6; T. 33).

130. Respondent told Patient E to not take any anti-inflammatory drugs like Motrin, to put ace bandages on her leg and to keep them on for five days (T. 32-33).

131. These were appropriate post treatment instructions (T. 336-337).

132. After the second treatment, Patient E's leg hurt as it did the first time. That night, she took the ace bandage off when she went to take a shower. She noticed two big blood clots on the bottom of her left leg on the front (T. 34-35).

133. The blood clots scabbed over, but did not heal. Later, the blood clots became very red (T. 35-36).

134. Patient E called the Visage office on or about June 13 and told an employee that there was an injury to her leg and that one of the veins in her ankle was very swollen and hurt. The person said she would talk to Respondent and would call her back. Patient E never received a return call (T. 35-36).

135. The symptoms described by the patient were most likely the result of extravasation, which means the sclerosant was actually injected outside of the vessel (T. 337).

136. In addition, the injections on June 1, 2006 were above the maximum recommended dose. The typical maximum recommended dose is 250 mg. Patient E received 7 cc. Since there were 50 mg/cc, this was a 350 mg dose (T. 337-338).

137. In addition to extravasation, it is also possible that the injection might have gone into a small arteriole, resulting in an infarct (T. 338).

138. Respondent is responsible for the proper functioning of his office. A reasonably prudent physician would ensure that Patient E received a return call (T. 339).

139. If the physician does not follow up, the patient can end up with a fairly extensive ulceration, infection or other complication. (T. 338).

140. On the morning of June 16, Patient E went to an urgent care center where an ultrasound of her left lower leg was done to

check for deep venous thrombosis. This was found to be negative. The staff gave Patient E an antibiotic, told her to keep her leg elevated, and to put warm compresses on it. She was diagnosed with left lower leg cellulitis and superficial phlebitis. Cellulitis is an infection of the subcutaneous space (Ex. 13, p. 2; T. 36-37, 340).

141. Patient E took several further steps in the evaluation and treatment of her left lower leg. She saw a vein specialist who gave her a prescription for Silvadine, a treatment for burns (Ex. 14, p. 2; T. 40-42).

142. Patient E also saw another physician who debrided the wound. By the fourth visit, both lesions of the anterior left leg were completely healed. The wound was ultimately healed with use of a hydro colloid dressing (Ex. 12, pp. 2-3; T. 43, 343).

143. Although sclerosants are supposed to be injected inside the vein, the injection of some these caustic agents outside the vein is an inevitable complication on occasion (T. 679).

PATIENT F

144. Respondent treated Patient F from on or about October 2005 to December 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy treatments for Patient F on or about January 12, 2006, and May 25, 2006 (Ex. 15).

145. The information documented by the Respondent on Patient F's medical history is a minimal history within the standard of a

reasonably prudent physician (Ex. 15, pp. 3-4; T. 362).

146. Respondent performed sclerotherapy on this patient initially on January 12, 2006, using sodium morrhuate (Ex. 15, p. 15).

147. Respondent's note does not list the concentration of sclerosant that was used (T. 365-366).

148. Respondent performed the first injection on January 12, 2006 and provided sufficient post-treatment instructions (Ex. 15, p. 15; T. 366).

149. Respondent also performed sclerotherapy on the patient on May 25, but did not document post-treatment instructions (Ex. 15, p. 8; T. 367).

150. Respondent failed to adequately document and/or describe the sclerotherapy procedures performed on May 25, 2006. The note of May 25, 2006 does not say what concentration was given. While the note of January 12, 2006 is minimally acceptable, the note of May 25, 2006 is substandard, and contrary to what a reasonably prudent physician would have documented (T. 368-369).

PATIENT G

151. Respondent treated Patient G from on or about May 2006 to May 2007, at Respondent's Visage Office. Respondent provided care including sclerotherapy treatments for Patient G on or about February 17, 2007 and May 5, 2007 (Ex. 17).

152. Respondent's medical history for the patient comports with minimum standards for a reasonably prudent physician (Ex. 17, pp. 3, 4, 10; T. 371).

153. The physical examination for the patient includes entries referencing the anatomy and classifying the veins (Ex. 17, p. 10; T. 492-493).

154. Respondent obtained a signed sclerotherapy informed consent from this patient by date of February 17, 2007. (Ex. 17, pp. 14-16).

155. Respondent documented the use of sodium morrhuate in his performance of sclerotherapy on the patient in February and May of 2007 (Ex. 17, pp. 7, 9).

156. Respondent's notations relating to the sclerotherapy procedure for February 17, 2007 does not identify the concentration of the agent that was used, and it does not clearly document the post-treatment instructions. The note does not contain the documentation of the procedure that a reasonably prudent physician would have documented (Ex. 17, p. 7; T. 375-376).

157. Respondent's procedure note for May 5, 2007 does not contain the information that a reasonably prudent physician would have documented about the procedure. There is no documentation of the concentration of sodium morrhuate used. The only information essentially contained in this documentation is that there were 2 cc's of sodium morrhuate that were injected (Ex. 17, p. 9; T. 376-377).

PATIENT H

158. Respondent treated Patient H from on or about January 2006 to May 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy on or about April 20, 2006 and laser treatment for Patient H (Ex. 18).

159. Respondent obtained and/or documented a minimally adequate history prior to performing sclerotherapy therapy on April 20, 2006 (Ex. 18, pp. 3, 4, and 13; T. 380-381).

160. The documented physical examination relates to Rosaceae, not sclerotherapy. Rosaceae is an inflammatory condition of the face. This cosmetic exam is not related to sclerotherapy at all (Ex. 18, p. 13; T. 381-382).

161. Respondent's documented physical examination prior to the performance of sclerotherapy on April 20, 2006 is not consistent with what a reasonably prudent physician would have documented (T. 382).

162.Respondent obtained Patient H's consent for the procedures (Ex. 18, p. 11).

163. Respondent used sodium morrhuate for the sclerotherapy procedure on April 20, 2006. The procedure note lists that the patient received 8 cc's of sodium morrhuate at 50 mg per ml, which is a concentration of the undiluted solution as purchased. This would be a 5% concentration, and that would be over the recommended dose (T. 385-386).

164. In addition, Respondent used an excessive amount of sodium morrhuate. The amount used here was 400 cc's, and the maximum should be 250 cc's. Thus this was excessive (T. 386-387).

PATIENT I

165. Respondent treated Patient I from on or about March 2006 to May 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy on or about April 22, 2006 and laser treatments for Patient I (Ex. 19, 20).

166. Respondent obtained and documented a minimally inadequate history prior to performing sclerotherapy therapy on April 22, 2006 (Ex. 19, pp. 3-4, 13; T. 388).

167. Respondent obtained Patient I's consent for the procedures that he performed (Ex. 19, p. 11).

168. Respondent's documented post-treatment instructions to this patient are limited to indicating that the patient should have compressions (T. 390).

169. Respondent's record does not indicate what concentration of sodium morrhuate was used. The documented procedure note does not contain the information that a reasonably prudent physician would have included in his note (Ex. 19, p. 12-13; T. 391).

170. On or about May 3, 2006, the patient was again seen in the office. There is a reference that the patient is concerned about "palpable nodules" at the site of the sclerotherapy. There is also a

reference to "induration" (Ex. 19, p. 12).

171. Nodules are medically significant because they are a complication of the procedure. Although it is difficult by looking at the record to understand what the diagnosis was, this could be anything from a pseudo aneurysm to a hematoma to an extravasation. It is unclear when the nodule appeared, what the symptoms associated with the nodule were, whether it was within the zone of injection, and the Respondent's diagnosis. It is also unclear what treatment was offered (T. 392).

172. The reference on May 3, 2006 to "mild induration" means a thickening or swelling of the dermal structure, almost a cord-like firmness (Ex. 19, p. 12; T. 392-393).

173. On May 13, 2006, the patient came in again. Respondent documented that the patient has a palpable induration in the popliteal area (Ex. 19, p. 12; T. 393).

174. It is difficult to know from the record what is happening with Patient I. The injection was given (by documentation) on the lateral left thigh. The induration as described is in the left popliteal region. The lateral thigh and the popliteal region are not attached, so if there is a connection between the two, it is unclear from the record (T. 393).

175. Respondent treated the patient with aloe cream which would not be part of the usual dermatologic armament (Ex. 19, p. 12; T.

393).

176. On June 13, 2006, Patient I went on to see another physician, who diagnosed a hematoma at the injection site. The area of hematoma was on the lateral area of the left lower extremity extending from the knee area behind the knee and up towards the thigh with induration and a phlebitic reaction. He used a micro-blade on the lateral aspect of the left lower extremity, removing a significant amount of clot all throughout the area of the vein. A compression bandage was applied (Ex. 20, p. 2; T. 394).

177. The physician administered the reasonably prudent care required for Patient I (T. 395).

178. Respondent, despite the patient developing dark nodules on or near her knees after the sclerotherapy procedure performed April 22, 2006, failed to adequately evaluate or treat the nodules, and/or failed to document that he adequately evaluated or treated the nodules (T. 395).

CONCLUSIONS OF LAW

Respondent is charged with twenty-two specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its

deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence and incompetence.

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

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

Gross Negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. 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 a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

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

The Hearing Committee first considered the credibility of

the various witnesses, and thus the weight to be accorded their testimony.

The Department presented testimony by Arup De, M.D. on the standard of care of a reasonably prudent anesthesiologist. Dr. De is board-certified by the American Board of Anesthesiology. He has been a staff anesthesiologist since 2003, and he has been an Assistant Professor of Anesthesiology for the past three years. His present practice is both academic and clinical.

Brett Schulman, M.D. provided testimony for the Department on the standard of care of a reasonably prudent physician performing sclerotherapy as well as other issues in the case that were not related to the administration of anesthesia. Dr. Shulman has maintained a private practice of dermatology for the past 25 years, which included performing sclerotherapy in his office.

The Respondent presented the testimony of Frederic Joyce, M.D. In addition to his experience as a thoracic surgeon, Dr. Joyce owned and operated a cosmetic practice.

The Hearing Committee determined that all three expert witnesses were credible. Dr. De has attained a high a level of education and experience in the area of anesthesiology, and Dr. Schulman has attained a high level of education and experience in sclerotherapy. Nonetheless, the Committee found that Dr. Joyce was forthright and knowledgeable. Therefore, the Committee determined

that Dr. Joyce's testimony regarding whether Respondent's conduct fell within minimally accepted standards of care by a reasonably prudent physician was entitled to some weight. On the other hand, the Hearing Committee concluded that Dr. De and Dr. Schulman were at times testifying to a standard that exceeded the minimally accepted standard of care.

The Respondent testified regarding his care of the nine patients. Although Respondent clearly has a stake in the outcome of these proceedings, the Hearing Committee did credit much of his testimony. For example, the Hearing Committee credited Respondent's testimony related to obtaining his patients' consent for the procedures that he performed even though his documentation was minimal. The Committee also believed that Respondent had performed the monitoring which he described, but that he failed to maintain the required documentation. Nonetheless, Respondent's failure to document his care and treatment of these patients often made it impossible for the Committee to obtain a complete understanding of the care he provided.

The Department presented the testimony of three patients as well as the spouse of one of those patients, and the Respondent presented the testimony of a licensed practical nurse. The Hearing Committee found the testimony of the Department's witnesses relating to driving themselves home after procedures using conscious sedation

to be more credible than the testimony of the licensed practical nurse who testified on Respondent's behalf.

The Hearing Committee determined that the Department established by a preponderance of the evidence that Respondent failed to obtain and/or document an adequate history and physical examination of the four patients who were administered conscious sedation (Patients A through D). An adequate medical history is critical to determine the types and amounts of anesthetic that should be administered to a patient during a procedure using conscious sedation. An adequate physical examination is necessary to assess the level of difficulty that a physician may have supporting the airway if the patient's respiratory drive is diminished or the patient's airway becomes obstructed and to assess the patient's heart and lungs. Respondent contended that he did perform an appropriate examination, but he did not document his findings. Under these circumstances, however, the Hearing Committee determined that a reasonably prudent physician would document his findings and that Respondent's repeated failure to document an adequate history and physical for these four patients constituted negligence on more than one occasion and a failure to maintain an adequate patient record. Moreover, the Respondent's own expert witness was forced to concede that that documentation was lacking in certain areas.

Respondent also failed to adequately document the

procedures which he performed. The record for Patient A does not contain any note for one of the two procedures that Respondent performed using conscious sedation. Respondent also conceded that there was no procedure note in the record for one of the procedures that performed on Patient D. Further Respondent's procedure notes for four of the sclerotherapy patients (Patients E, F, G, I) are inadequate including his failure to document the concentration of the injected sclerosant. The Hearing Committee concluded that Respondent's failure to adequately document the procedures that he performed constituted negligence and a failure to maintain adequate patient records.

The Department further established that Respondent failed to monitor and/or document his monitoring of Patients A through D when he performed procedures using conscious sedation. Although the Hearing Committee felt that the testimony of Dr. De was generally entitled to greater weight on issues related to anesthesia, it felt that the Department had not established by a preponderance of the evidence that EKG monitoring was required during these procedures in light of testimony of Dr. Joyce and the period of time that elapsed since these procedures were performed by Respondent. The Department did, however, establish that the patient's blood pressure and pulse should have been monitored during the procedures, yet Respondent acknowledged that the monitoring strips were A through D constituted

negligence and a failure to maintain adequate patient records.

The Hearing Committee also found that Respondent failed to meet minimally accepted standards of care when he continued to prescribe Xanax for monthly periods to Patient D for whom he was providing cosmetic treatment without conducting a full medical evaluation and advising the patient's primary care physician. The Hearing Committee concluded that this failure was also negligence.

The Department established that Patient E called Respondent's office to report an adverse medical condition, and that Respondent failed to return her call. It was also established that Respondent was obligated to set up office systems that would ensure that he received messages of such communications. The Committee considered this failure to constitute negligence; however, it noted that a pattern or practice of failing to return patient calls was not charged or established.

Since the medical record of Patient H contains no documentation of a physical examination, the Department has established that Respondent failed to maintain an adequate record for that patient.

The Hearing Committee determined that the Department had not established by a preponderance of the evidence that Respondent's use of Sodium Morrhuate did not meet minimally accepted standards of patient care. Although the Dr. Schulman established that there are

other sclerosants that have a better risk/benefit profile, the record establishes that sodium morrhuate is an FDA approved sclerosant. Based on the testimony of Dr. Joyce, the Hearing Committee determined that the use of sodium morrhuate was within the minimally accepted standard of care at the time.

Finally, the Hearing Committee concluded that the Department had not established by a preponderance of the evidence that Respondent failed to obtain patient consent for the cosmetic procedures that he performed or that his minimal documentation of that consent constituted misconduct. Both parties agreed that the risks, benefits and alternatives of a procedure must be discussed with the patient. Dr. Schulman's testimony that the risks, benefits and alternatives of a procedure had to written down and the patient's signature obtained was countered by the testimony of Dr. Joyce who indicated that the patient's consent after a discussion of these matters was all that was required in order to meet minimally accepted standards.

Factual Allegations

The vote of the Hearing Committee on the factual allegations contained in the Statement of Charges is as follows:

Paragraph A - A.1	Sustained
Paragraph A - A.2	Sustained
Paragraph A - A.3	Sustained
Paragraph A - A.4	Sustained

Paragraph A - A.5	Not Sustained
Paragraph A - A.6	Sustained
Paragraph B - B.1	Sustained
Paragraph B - B.2	Sustained
Paragraph B - B.3	Sustained
Paragraph B - B.4	Not Sustained
Paragraph B - B.5	Withdrawn
Paragraph C - C.1	Sustained
Paragraph C - C.2	Sustained
Paragraph C - C.3	Sustained
Paragraph C - C.4	Not Sustained
Paragraph C - C.5	Withdrawn
Paragraph D - D.1	Sustained
Paragraph D - D.2	Sustained
Paragraph D - D.3	Sustained
Paragraph D - D.4	Sustained
Paragraph D - D.5	Sustained
Paragraph D - D.6	Sustained
Paragraph D - D.7	Sustained
Paragraph D - D.8	Not Sustained
Paragraph D - D.9	Withdrawn
Paragraph E - E.1	Withdrawn
Paragraph E - E.2	Not Sustained
Paragraph E - E.3	Not Sustained
Paragraph E - E.4	Not Sustained
Paragraph E - E.5	Sustained
Paragraph E - E.6	Sustained
Paragraph E - E.7	Sustained
Paragraph E - E.8	Not Sustained
Paragraph F - F.1	Not Sustained
Paragraph F - F.2	Withdrawn
Paragraph F - F.3	Not Sustained
Paragraph F - F.4	Not Sustained
Paragraph F - F.5	Sustained
Paragraph F - F.6	Sustained
Paragraph F - F.7	Withdrawn
Paragraph G - G.1	Not Sustained
Paragraph G - G.2	Not Sustained
Paragraph G - G.3	Not Sustained
Paragraph G - G.4	Not Sustained

Paragraph G - G.5	Sustained
Paragraph G - G.6	Sustained
Paragraph G - G.7	Withdrawn
Paragraph H - H.1	Not Sustained
Paragraph H - H.2	Sustained
Paragraph H - H.3	Not Sustained
Paragraph H - H.4	Not Sustained
Paragraph H - H.5	Withdrawn
Paragraph H - H.6	Withdrawn
Paragraph I - I.1	Not Sustained
Paragraph I - I.2	Withdrawn
Paragraph I - I.3	Not Sustained
Paragraph I - I.4	Not Sustained
Paragraph I - I.5	Not Sustained
Paragraph I - I.6	Sustained
Paragraph I - I.7	Sustained

Specifications

The First through Ninth Specifications charged Respondent with practicing with gross negligence on a particular occasion, in violation of New York Education Law §6530(4) with respect to each of the named patients. The Hearing Committee found Respondent's treatment of these patients did not rise to the level of gross negligence. By a unanimous vote, the First through Ninth Specifications are **Dismissed.**

The Twelfth through Twentieth Specifications charged Respondent with practicing with gross incompetence within the meaning of New York Education Law §6530(6). The Hearing Committee found Respondent's treatment of these patients was negligent rather than

incompetent. By a unanimous vote, the Twelfth through Twentieth Specifications are **Dismissed**.

The Twenty-third Specification charged Respondent with practicing the profession with negligence on more than one occasion, in violation of New York Education Law §6530(3). Given the fact that the Committee has found multiple instances of negligence involving the patients whose care is at issue, the Twenty-third Specification is **Sustained** by a unanimous vote.

The Twenty-fourth Specification charged Respondent with practicing with incompetence on more than one occasion, in violation of New York Education Law §6530(5). The Committee concluded the record does not establish that Respondent's actions in regard to the allegations charged demonstrate incompetence. Accordingly, the Twenty-fourth Specification is **Dismissed**.

The Twenty-fifth Specification charged Respondent with performing services which had not been duly authorized by the patient, in violation of New York Education Law §6530(26). As stated above, the Committee concluded Respondent had obtained the consent of the patients specified. Accordingly, the Twenty-fifth Specification is **Dismissed**.

The Twenty-ninth Specification charged Respondent 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). The Hearing Committee unanimously concluded that Respondent's records for each of the named patients were inadequate. Accordingly, the Twenty-ninth Specification is **Sustained.**

The Tenth, Eleventh, Twenty-first, Twenty-second, Twenty-sixth, Twenty-seventh and Twenty-eighth Specifications were withdrawn by the Department.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent should be censured and reprimanded for his misconduct. The Committee further determined that Respondent should be placed on probation for three years. In order to ensure that Respondent's negligence and inadequate record-keeping demonstrated in his operation of the cosmetic practice does not extend into his other areas of practice, the terms of probation must include a requirement that Respondent successfully complete a continuing education program in the medical documentation and that Respondent's practice of medicine be monitored. The Hearing Committee accepted the Department's recommendation that, within thirty days of the effective date of this Determination and Order, Respondent may only practice

medicine when monitored by a physician proposed by the Respondent and approved by the Director of the Office of Professional Medical Conduct. The terms of the probationary period and the monitoring requirement are set out in greater detail in the Attachment A which is annexed hereto and made part of this Determination and Order.

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. The Hearing Committee believes that Respondent has the requisite knowledge and skill to practice medicine safely, but that he has repeatedly failed to exercise the care that a reasonably prudent physician would exercise under the circumstances. The Committee decided upon this penalty to permit Respondent to continue to practice his chosen profession while ensuring the safety of his patients.

ORDER

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

1. The Twenty-third and Twenty-ninth Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED**;

2. The remaining Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent is hereby **CENSURED AND REPRIMANDED**;

4. Respondent is placed on **PROBATION FOR A PERIOD OF THREE YEARS**;

5. Respondent is required to **COMPLY WITH THE TERMS OF PROBATION** annexed hereto as Attachment A;

6. As one of the terms of probation, Respondent may only practice medicine during the probationary period if within 30 days of the effective date of this order he has a licensed physician serve as a **PRACTICE MONITOR**; and

7. 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: Syracuse, New York
JANUARY 30 , **2012**

REDACTED SIGNATURE

PETER KANE, M.D. (CHAIR)

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ATTACHMENT "A"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of his license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 1000, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of his employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with and respond in a timely manner to OPMC requests to provide written periodic verification of his compliance with these terms. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject him to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director

of OPMC, in writing, if he is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in the Determination and Order or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

9. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE MONITOR

10. Within thirty days of the Determination and Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient

records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

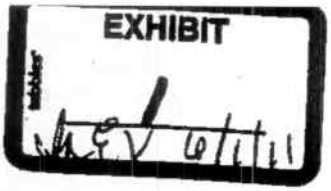
c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall 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. Proof of coverage shall be submitted to the Director of OPMC within 30 days after the effective date of this Order.

11. Respondent shall enroll in and successfully complete a continuing education program in the area of obtaining and documenting adequate medical histories and physical examinations, and overall adequate documentation of care for a minimum of 40 credit hours. This continuing education program is subject to the Director of OPMC's prior written approval and shall be successfully completed within the first 90 days of the probation period.

12. Respondent shall comply with these probationary terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

APPENDIX I



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

IN THE MATTER

OF

IFECHUKWUDE OJUGBELI, M.D.

NOTICE

OF

HEARING

TO: IFECHUKWUDE OJUGBELI, M.D.
3709 Erie Boulevard East
Dewitt, New York 13214

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 June 10, 2011, at 10:00 a.m., in Conference Rooms 4A/B at the Offices of the New York State Department of Health, Syracuse Area Office, 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.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here_____

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
April 29, 2011

REDACTED SIGNATURE

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

Inquiries should be directed to: Michael A. Hiser, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
Room 2588, Corning Tower
Division of Legal Affairs
New York State Department of Health
Empire State Plaza
Albany, New York 12237
518-473-4282

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

IN THE MATTER

OF

IFECHUKWUDE OJUGBELI, M.D.

STATEMENT

OF

CHARGES

IFECHUKWUDE OJUGBELI, M.D., the Respondent, was authorized to practice medicine in New York State on March 12, 1998, by the issuance of license number 209777 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patients are identified in the attached appendix) from on or about June 2005 to September 2007, at Visage Medical Aesthetics, 3709 Erie Blvd., Dewitt, N.Y. (hereafter, "Respondent's Visage Office"). Respondent performed procedures including a "jowl lift" or "curl (thread) lift" on or about May 26, 2006. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing a surgical procedure on the patient using conscious sedation in May 2006.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing a surgical procedure on the patient using conscious sedation.

3. Respondent, during the "jowl lift" or "curl (thread) lift" performed under conscious sedation on or about May 26, 2006, failed to adequately monitor the patient's vital signs, cardiac activity, oxygen saturation, and the period of anesthesia, among others, and/or document that he adequately monitored such items.

4. Respondent, within a week or two after he performed the "jowl lift" or "curl (thread) lift" on or about May 26, 2006, performed an additional procedure on Patient A at a location different from the Visage Office. Respondent, failed to adequately document that he performed an additional procedure on Patient A related to her initial surgery of May 26, 2006.

5. Respondent failed to obtain and/or document appropriate patient consent for procedures and/or treatments, including the "jowl lift" or "curl (thread) lift" of May 26, 2006, any additional procedure related to the "jowl loft" thereafter, Botox treatments, "fat grafting and transfer" performed June 24, 2006, and/or laser treatments, among others.

6. Respondent failed to adequately document the procedures performed.

B. Respondent treated Patient B from on or about April 2006 to May 2006, at Respondent's Visage Office. Respondent performed a "contour thread lift mid face and curl lift to the neck" on or about May 22, 2006. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing a surgical procedure on the patient using conscious sedation.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing a surgical procedure on the patient using conscious sedation.

3. Respondent, during the "contour thread lift mid face and curl lift to the neck" procedure performed under conscious sedation on or about May 22, 2006, failed to adequately monitor oxygen saturation and the period of anesthesia, among others, and/or document that he adequately monitored such items.

4. Respondent failed to obtain and/or document appropriate patient consent for procedures and/or treatments.

~~5. Respondent failed to adequately document the procedures performed.~~ Withdrawn 1/22/11

C. Respondent treated Patient C from on or about September 2005 to July 2006, at Respondent's Visage Office. Respondent performed procedures including a "contour thread lift jowl line and curl lift to the neck" on or about May 20, 2006. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing a surgical procedure on the patient using conscious sedation, including the patient's history of being hospitalized from July 27 through August 2004 for an intra cranial hemorrhage, with subsequent inpatient rehabilitation.

2. Respondent failed to perform and/or document an adequate physical

examination and evaluation prior to performing a surgical procedure on the patient using conscious sedation.

3. Respondent, during the "contour thread lift jowl line and curl lift to the neck" procedure performed under conscious sedation on or about May 20, 2006, failed to adequately monitor vital signs, cardiac activity, oxygen saturation, and the period of anesthesia, among others, and/or document that he adequately monitored such items.

4. Respondent failed to obtain and/or document appropriate patient consent for procedures and/or treatments.

~~5. Respondent failed to adequately document the procedures performed.~~
Withdrawn 11/22/11

D. Respondent treated Patient D from on or about March 2006 to January 2008, at Respondent's Visage Office. Respondent performed procedures including a "contour thread lift of mid-face" on or about March 20, 2006, a "revised contour thread lift" on or about April 10, 2006, and a "removal of contour thread right side of the face and curl lift" on or about June 9, 2006. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing surgical procedures on the patient using conscious sedation.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing surgical procedures on the patient using conscious sedation.

3. Respondent, during the "contour thread lift of mid face" procedure performed under conscious sedation on or about March 20, 2006, failed to adequately monitor vital signs, cardiac activity, oxygen saturation, and the period of anesthesia, among others, and/or document that he adequately monitored such items.

4. Respondent, during the "revised contour thread lift" procedure performed under conscious sedation on or about April 10, 2006, failed to adequately monitor vital signs, cardiac activity, oxygen saturation, and the period of anesthesia, among others, and/or document that he adequately monitored such items.

5. Respondent failed to adequately document the procedure performed on or about April 10, 2006.

6. Respondent, during the "removal of contour thread right side of the face and curl lift" procedure performed under conscious sedation on or about June 9, 2006, failed to adequately monitor vital signs, cardiac activity, oxygen saturation, and the period of anesthesia, among others, and/or document that he adequately monitored such items.

7. Respondent prescribed Xanax for the patient on multiple occasions despite the fact she was being treated by another physician, without informing the other physician of his treatment, and/or documenting that he informed the other physician of his prescribing Xanax.

8. Respondent failed to obtain and/or document appropriate patient consent for multiple procedures and/or treatments.

~~9. Respondent failed to adequately document the procedures performed.~~ Withdrawn 11/22/11

E. Respondent treated Patient E from on or about May through June 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy and laser therapy for Patient E on or about May 17, 2006 and June 1, 2006. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care, in that:

~~1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy and/or laser therapy.~~ Withdrawn 8/12/11 JWL

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy and/or laser therapy.

3. Respondent failed to obtain and/or document appropriate patient consent for sclerotherapy and laser treatments.

4. Respondent inappropriately used Sodium Morrhuate for sclerotherapy on May 17, 2006 and/or June 1, 2006.

5. Respondent failed to adequately document and/or describe the procedures performed, including the concentrations of injected materials used.

6. Respondent failed to provide and/or document appropriate post-treatment instructions.

7. Respondent, after the patient contacted his office on or about 6/13/06 to complain about red and swollen areas on her legs, and pain, failed to contact the patient.

8. Respondent, through his use of Sodium Morrhuate on Patient E, caused the patient to suffer a burn and scarring on her left leg.

F. Respondent treated Patient F from on or about October 2005 to December 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy treatments for Patient F on or about January 12, 2006, and May 25, 2006. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care, in that :

1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy therapy on January 12, 2006 and/or May 25, 2006.

2. ~~Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy therapy on January 12, 2006 and/or May 25, 2006.~~ withdrawn 11/22/11

3. Respondent failed to obtain and/or document appropriate patient consent for sclerotherapy treatment on January 12, 2006 and/or May 25, 2006.

4. Respondent inappropriately used Sodium Morrhuate for sclerotherapy on January 12, 2006 and/or May 25, 2006.

5. Respondent failed to provide and/or document appropriate post-treatment instructions for the sclerotherapy procedures of January 12, 2006 and/or May 25, 2006.

6. Respondent failed to adequately document and/or describe the sclerotherapy procedures performed on January 12, 2006 and/or May 25, 2006.

7. ~~Respondent, despite documenting on or about June 8, 2006, that the patient had post sclerotherapy phlebitis, failed to adequately evaluate and treat the patient, and/or failed to document that he adequately evaluated or treated the patient.~~ withdrawn 11/22/11

G. Respondent treated Patient G from on or about May 2006 to May 2007, at Respondent's Visage Office. Respondent provided care including sclerotherapy treatments for Patient G on or about February 17, 2007 and May 5, 2007. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy therapy on February 17, 2007 and/or May 5, 2007.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy therapy on February 17, 2007 and/or May 5, 2007.

3. Respondent failed to obtain and/or document appropriate patient consent for sclerotherapy on February 17, 2007 and/or May 5, 2007, and laser treatments.

4. Respondent inappropriately used Sodium Morrhuate for the sclerotherapy procedures of 2/17/07 and/or 5/5/07.

5. Respondent failed to adequately document and/or describe the sclerotherapy procedure performed on February 17, 2007.

6. Respondent failed to adequately document and/or describe the sclerotherapy procedure performed on May 5, 2007.

~~7. Respondent failed to provide and/or document appropriate post-treatment instructions for the sclerotherapy procedures of 2/17/07 and/or 5/5/07.~~ Withdrawn 11/22/11

H. Respondent treated Patient H from on or about January 2006 to May 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy on or about April 20, 2006 and laser treatment for Patient H. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy therapy on April 20, 2006.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy therapy on April 20, 2006.

3. Respondent failed to obtain and/or document appropriate patient consent for sclerotherapy and laser treatments.

4. Respondent inappropriately used Sodium Morrhuate for the sclerotherapy procedure on April 20, 2006.

~~5. Respondent failed to provide and/or document appropriate post-treatment instructions following the sclerotherapy procedure on April 20, 2006.~~ Withdrawn 11/22/11

~~6. Respondent failed to adequately document and/or describe the~~

~~sclerotherapy procedure performed April 20, 2006.~~ 8/12/11
Withdrawn No 2

I. Respondent treated Patient I from on or about March 2006 to May 2006, at Respondent's Visage Office. Respondent provided care including sclerotherapy on or about April 22, 2006 and laser treatments for Patient I. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care, in that:

1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy therapy on April 22, 2006.

2. ~~Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy therapy on April 22, 2006.~~ Withdrawn 11/22/11

3. Respondent failed to obtain and/or document appropriate patient consent for the sclerotherapy procedure performed April 22, 2006, and laser treatments.

4. Respondent inappropriately used Sodium Morrhuate for the sclerotherapy procedure performed April 22, 2006.

5. Respondent failed to provide and/or document appropriate post-treatment instructions after the sclerotherapy procedure performed April 22, 2006.

6. Respondent failed to adequately document and/or describe the sclerotherapy procedure performed April 22, 2006 and/or the laser procedures.

7. Respondent, despite the patient developing dark nodules on or near her knees after the sclerotherapy procedure performed April 22, 2006, failed to adequately evaluate or treat the nodules, and/or failed to document that he adequately evaluated or treated the nodules.

~~J. Respondent treated Patient J from on or about March 2007 to June 2007, at Respondent's Visage Office. Respondent provided care including sclerotherapy on or about March 27, 2007, and laser treatments for Patient J. Respondent's care and treatment of Patient J failed to meet accepted standards of medical care, in that:~~ 8/12/11

1. Respondent failed to obtain and/or document an adequate history prior to performing sclerotherapy therapy on March 27, 2007.

2. Respondent failed to perform and/or document an adequate physical examination and evaluation prior to performing sclerotherapy therapy on March 27, 2007.

3. Respondent failed to obtain and/or document appropriate patient consent for the sclerotherapy procedure performed March 27, 2007, and/or laser treatments.

4. Respondent inappropriately used Sodium Morrhuate for the sclerotherapy procedure performed March 27, 2007.

5. Respondent failed to provide and/or document appropriate post-treatment instructions following the sclerotherapy of March 27, 2007.

6. Respondent failed to adequately document and/or describe the sclerotherapy procedure performed March 27, 2007.

K. Respondent treated Patient K from on or about December 2007 to on or about January 2008, at Respondent's Visage Office. Respondent's care and treatment of Patient K failed to meet accepted standards of medical care, in that:

1. Respondent, either personally or acting through his office staff, arranged for Patient K to be issued a credit card with "CareCredit" without her knowledge or consent.

2. Respondent, on or about December 8, 2007, failed to obtain and/or document appropriate patient consent for botox and/or juvederm therapy, and/or refused to respond to the patient's questions during the procedures as to why he was doing injections in the areas of her eyes.

3. Respondent, on or about January 5, 2008, failed to obtain and/or document appropriate patient consent for botox and/or juvederm therapy and/or refused to respond to the patient's questions during the procedures as to why he was doing injections in the areas of her eyes.

4. Respondent billed Patient K's credit card for services for December 8, 2007 and January 5, 2008, at a total cost of $3,125 dollars, an amount that was contrary to the patient's knowledge or consent.

6/10/11

SPECIFICATIONS

FIRST THROUGH TENTH 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 A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6.

2. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

3. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, and/or C and C.5.

4. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, and/or D and D.9.

5. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, and/or E and E.8.

6. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6 and/or F and F.7.

7. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, and/or G and G.7.

8. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

9. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6 and/or I and I.7.

~~10. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, and/or J and J.6.~~

~~11. The facts in Paragraphs K and K.2 and/or K and K.3.~~

Withdrawn 6/10/11

TWELFTH THROUGH TWENTY-SECOND SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York

Education Law §6530(6) in that, Petitioner charges:

12. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6.

13. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

14. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, and/or C and C.5.

15. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, and/or D and D.9.

16. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, and/or E and E.8.

17. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6 and/or F and F.7.

18. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, and/or G and G.7.

19. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

20. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6 and/or I and I.7.

~~21. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, and/or J and J.6.~~

~~22. The facts in Paragraphs K and K.2 and/or K and K.3.~~

Withdraw 6/10/11
MPL

TWENTY-THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

23. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G

and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, J and J.1, ~~J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, K and K. 2 and/or K and K.3~~.

6/10/11

TWENTY-FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

24. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, ~~J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, K and K. 2~~ and/or ~~K and K.3~~.

6/4/11

TWENTY-FIFTH SPECIFICATION

PERFORMING SERVICES NOT DULY AUTHORIZED

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

25. The facts in Paragraphs A and A.5, B and B.4, C and C.4, D and D.8, E and E.3, F and F.3, G and G.3, H and H.3, I and I.3, ~~J and J.3, K and K.2~~, and/or ~~K and K.3~~.

6/10/11

TWENTY-SIXTH SPECIFICATION

EXERCISING UNDUE INFLUENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(17) by exercising undue influence on the patient, in such a way as to exploit the patient for the financial gain of the licensee or a third party, as alleged in the facts of:

26. The facts in Paragraphs K and K.1, K and K.2, and/or K and K.3.

Withdrawn 6/10/11

TWENTY-SEVENTH SPECIFICATION

FRAUDULENT PRACTICE

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

27. The facts in Paragraphs K and K.1, K and K.2, K and/or K.3, and/or K and K.4.

Withdrawn 6/10/11

TWENTY-EIGHTH SPECIFICATION

MORAL UNFITNESS

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

28. The facts in Paragraphs K and K.1, K and K.2, K and/or K.3, and/or K and K.4.

Withdrawn 6/10/11

TWENTY-NINTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain records which accurately reflect evaluation and treatment in violation of New York Education Law §6530(32) in that, Petitioner charges:

29. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.5, G and G.6, G and G.7, H and H.1, H and H.2, H and H.3, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.5, I and I.6, I and I.7, ~~J and J.1, J and J.2, J and J.3, J and J.5, J and J.6, K and K. 2~~ and/or ~~K and K.3~~.

Withdrawn 6/10/11

DATED: April 28, 2011
Albany, New York

REDACTED SIGNATURE

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