Public

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

December 19, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Joel Abelove, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

James D. Lantier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street – Suite 600
Syracuse, New York 13202-1252

Sandeep K. Johar, D.O.
c/o James D. Lantier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street – Suite 600
Syracuse, New York 13202-1252

RE: In the Matter of Sandeep K. Johar, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-315) 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. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "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
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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

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

Sincerely,

REDACTED

James F. Horan
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 OF SANDEEP K. JOHAR, D.O.	DETERMINATION AND ORDER

BPMC #14-315

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("the Department"). A Notice of Hearing ("NOH") and Statement of Charges ("SOC") both dated April 28, 2014 were served on Sandeep K. Johar, D.O. ("Respondent"), and hearings were held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401 on June 17, 2014 and July 29, 2014 at the Department's offices at 90 Church Street, New York, New York. A copy of the NOH and SOC is attached to this Determination and Order as Appendix 1. Initially, Carolyn C. Snipe, Chair, Elisa J. Wu, M.D., and Joel M. Zinberg, M.D., duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Hearing Committee" "Committee" or "Panel") in this matter; subsequent to the last hearing date but prior to the date deliberations were ultimately held, Joan Martinez-McNicholas was appointed as Chair of the Committee[1]. Ann H. Gayle, Administrative Law Judge ("ALJ"), served as the Administrative Officer. The Department appeared by James E. Dering, Esq., General Counsel, by Joel Abelove, Associate Counsel. The Respondent appeared by James D. Lantier, Esq., of Smith Sovik Kendrick & Sugnet, P.C. Evidence was received, including witnesses who were sworn or affirmed, and a transcript of this proceeding was made.

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[1] *Pursuant to PHL §230.10(f), due to the death of the original Committee chair, Joan Martinez-McNicholas was immediately appointed and she affirms that she has read and considered evidence and transcripts of the prior*

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

PROCEDURAL HISTORY

Date of Service of NOH and SOC:	April 30, 2014
Answer Filed:	May 7, 2014
Pre-Hearing Conference:	June 17, 2014
Hearing Dates:	June 17, 2014 and July 29, 2014[2]
Witness for Petitioner:	Jeffrey L. Margulies, MD
Witnesses for Respondent:	Respondent Arnold James Ciaccio, MD
Deliberations Date:	November 25, 2014[3]

STATEMENT OF THE CASE

The Department charged the Respondent with two specifications of professional misconduct under N.Y. Educ. Law §6530 which included practicing medicine with negligence on more than one occasion §6530(3) and practicing medicine with incompetence on more than one occasion §6530(5). Respondent denied each of the specifications and factual allegation A.1. Respondent alleged that the standard of care did not require "reassessments" of the Patient's ECG and Troponin (A.2) and that (while the term "conclusion" of his medical condition is not understood) discharge was appropriate under the circumstances (A.3). Respondent asserted that

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proceedings.

[2] *At the conclusion of testimony on July 29, the Department considered calling a rebuttal witness on a subsequent date unless the Parties could reach a stipulation. On August 7, 2014, the Bureau of Adjudication received a Stipulation from the Parties that was marked in evidence by the ALJ as Department's Exhibit 8, and it was forwarded to the Panel Members. On August 11, Respondent's counsel confirmed that Respondent rested, and on August 12, the Department rested. Additionally scheduled dates were canceled and the record closed on August 14.*

[3] *Two Committee Members and the ALJ appeared on the originally scheduled Deliberations date of September 23, 2014; due to the death of the third Committee Member, Deliberations were rescheduled and held on November 25.*

use of a nasograstric tube, in consideration of risk to benefit evaluation, was indicated and appropriately performed (B.1) and the insulin drip was medically indicated and resulted from appropriate consultation (B.2).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Citations in brackets, which refer to transcript page numbers ["T"] and exhibits ["Ex"] that were accepted into evidence, represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings are unanimous.

1. Respondent was authorized to practice medicine in New York State on or about July 10, 2006, by the issuance of license number 240948 by the New York State Education Department. [Ex 1; Ex 3]
2. Respondent was responsible for the care and treatment of Patients A and B in his capacity as a locum tenens Emergency Medicine ("EM") physician for the Faxton St. Luke's Healthcare Emergency Department ("Faxton St. Luke's") in Utica, New York on the following dates in 2009: April 13–Patient B, and September 9–Patient A. [Ex 4; Ex 5; T 202-203, 211-213, 225, 229]
3. A patient's care is transferred from one EM physician to another in an Emergency Department ("ED" or "ER") at a shift change. Because one shift ends *e.g.* at 7 a.m. and the next shift starts at that same time, there is overlap between the transferring and receiving physicians for the care of the patient. The transferring physician reports presentation, pertinent findings, differential diagnoses, what was already ordered, and what lab or therapeutics may have to be ordered, continued, and/or reevaluated. The receiving physician

must hear and question the information being transferred and digest the handoff. The receiving physician, who then "owns" the patient and becomes responsible for anything that happens from that point on, must make judgment calls of what to do next to care for the patient based on the information provided by the transferring physician and what occurs after the handoff. [T 28-29, 67-68, 84-87]

Patient A

4. On September 9, 2009, Respondent provided care to Patient A, a 49 year old male who presented to Faxton St. Luke's complaining of abdominal pain, nausea, vomiting and bloody diarrhea. [Ex 4]
5. Respondent reviewed Patient A's earlier diagnostic test results. [Ex 4; T 48, 81-82, 373-377, 390-392]
6. It was appropriate to not perform reassessments of Patient A's ECG and Troponin. [Ex 4; T 75-81, 262-264, 394-395]
7. Patient A was appropriately discharged from the ER. [Ex 4; T 269-271]

Patient B

8. On April 13, 2009, Respondent provided care to Patient B, a 45 year old female with a history of diabetes and hypertension, who presented to Faxton St. Luke's after taking a medication overdose. [Ex 5]
9. It was appropriate, after being advised by Poison Control, to attempt to use a nasogastric tube for gastrointestinal irrigation on Patient B. [Ex 5; T 165-167, 177-180, 408-409]
10. It was appropriate, after being advised by Poison Control, to use an insulin drip to treat Patient B's calcium-channel blocker overdose. [Ex 5; Ex B; Ex C; Ex G; Ex H; T 108-109, 358-359]

FACTUAL ALLEGATIONS NOT SUSTAINED

The Committee unanimously determined that the following factual allegations were not sustained:

Patient A

The Department charged Respondent with failing to adequately review Patient A's earlier diagnostic test results (A.1), and Respondent denied this factual allegation. Respondent did not have a specific recollection of Patient A whose course in the ER five years ago was not "out of the ordinary" or "unusual" (T 377), therefore Respondent testified about his custom and practice to review the charts of the patients transferred to him at handoff at the beginning of his shift. Respondent testified that by following his usual custom and practice, he would have reviewed Patient A's earlier diagnostic test results, and the Department's expert inferred, based on Respondent's notation at page 7 of exhibit 4, that Respondent fully reviewed the transferring physician's diagnostic workup. Therefore, the Committee finds that Respondent reviewed Patient A's earlier diagnostic test results, and as such the Department did not prove this factual allegation. [Ex 4, p 7; T 48, 81-82, 373-377, 390-392]

The Department charged Respondent with failing to perform appropriate reassessments of Patient A's ECG[4] and Troponin (A.2), and Respondent alleged that the standard of care did not require "reassessments" of the Patient's ECG and Troponin. By the time Respondent saw Patient A in the ER, there was at least a 24-hour duration of his symptoms which included nausea, vomiting, bloody diarrhea, and diffuse abdominal pain. Furthermore, his vital signs and oxygen saturation were normal, there was no shortness of breath, chest pain, or pain radiating down his arm, and his vital signs remained normal with no onset of additional symptoms during

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[4] *The terms "EKG" and "ECG" which refer to an electrocardiogram were used interchangeably by the witnesses and those questioning the witnesses, and will be used interchangeably in this Determination and Order.*

his course in the ER. The Department's expert, Dr. Margulies, testified that he thought there was a 5% chance that Patient A was having a myocardial infarction ("MI") based on the nonspecific EKG findings that were not diagnostic. Dr. Margulies believed the Troponin and ECG should have been repeated. He claimed the ECG had nonspecific changes that were borderline abnormal but could represent normal variants. Respondent's expert, Dr. Ciaccio, testified that the standard of care would not have required a repeat of the EKG/ECG for someone with vomiting, bloody diarrhea and crampy abdominal pain or a repeat of the normal Troponin level in conjunction with the timing of the onset of symptoms, such a low possibility of acute coronary syndrome, and test findings supporting an abdominal condition. The Committee, in giving greater weight to Dr. Ciaccio's testimony (to be discussed further in "Discussion" section), finds that the Department did not prove this factual allegation. [Ex 4, p 15-17, 28, 32; T 75-81, 262-264, 278-279, 394-395]

The Department charged Respondent with discharging Patient A before adequate conclusion of his medical condition (A.3) and Respondent alleged that (while the term "conclusion" of his medical condition is not understood) discharge was appropriate under the circumstances. Dr. Ciaccio testified that Respondent's discharging this 49 year old male with vomiting, bloody diarrhea, and crampy abdominal pain, essentially unremarkable lab work and relatively normal vital signs, who responded to treatment and tolerated fluids, was "absolutely consistent with standards of care" (T 270). The Committee finds that the chart and testimony demonstrate that Patient A's problem was gastrointestinal and he was getting better, therefore discharge was appropriate at the time Respondent discharged him from the ER. The Committee therefore finds that the Department did not prove this factual allegation. [Ex 4; T 269-271, 294, 302-303]

In conclusion, the Committee unanimously concludes that the Department did not prove any of the factual allegations regarding Patient A, and Respondent did establish that the standard of care did not require reassessments of Patient A's ECG and Troponin and that discharge was appropriate under the circumstances.

Patient B

The Department charged Respondent with inappropriately attempting to use a nasogastric tube on Patient B, thereby unnecessarily increasing the risk of complications and morbidity (B.1), and Respondent asserted that use of the nasogastric tube, in consideration of risk to benefit evaluation, was indicated and appropriately performed. The Department's expert erroneously believed and/or assumed that the nasogastric tube ("NG tube") was used for aspiration (not irrigation) but Respondent's undisputed testimony (which is corroborated by the 10:20 note at page 20 of exhibit 5) is that the NG tube was used for bowel irrigation pursuant to Poison Control's recommendation. The 4/13 10:20 note on page 20 of exhibit 5 which reads in part, "WHOLE BOWEL IRRIGATION" links the NG tube with the purpose for it: irrigation, not aspiration. Furthermore, there was no credible evidence to support the Department's assertion that using the NG tube was wrong; the closest Dr. Margulies came to showing that using the NG tube was inappropriate was when he testified that his recollection was that 2009 textbooks would have said "don't do it" (T 178). However, that was quickly dispelled when Dr. Margulies, in acknowledging that he did not recently look at those textbooks from which he was forming such opinion, stated, "I'm embarrassed. I'm not as refreshed as I would have liked to have been. You got me" (T 180). Finally, the Committee found that when Dr. Margulies conceded that Poison Control must be contacted in any potential overdose situation, and that he "would not say that it's wrong to follow Poison Control" (T165-166), he was admitting that there was no deviation

by Respondent. The Committee therefore finds that Respondent's attempt to use a nasogastric tube on Patient B was indicated and appropriate, and as such, finds that the Department did not prove this factual allegation. [Ex 5, p 20; T 165-167, 177-180, 408-409]

The Department charged Respondent with using an insulin drip without adequate medical indication (B.2), and Respondent asserted that the insulin drip was medically indicated and resulted from appropriate consultation with Poison Control. Dr. Margulies, who focused on insulin's use for diabetes (rather than for calcium-channel blocker overdose) for a good portion of his testimony, testified that he was "not sure why the insulin was given" (T 109) but a few seconds later stated that Poison Control recommended it. Respondent's use of insulin was for the purpose of combatting the extended release calcium-channel blocker and not for her diabetes. Respondent's expert, Dr. Ciaccio, testified that there was adequate medical indication for the insulin drip, and the articles in evidence on this point support that. In contrast, Dr. Margulies seemed to the Panel to be unaware that insulin is used as a treatment for poisoning caused by calcium-channel blocker overdose. Dr. Margulies also claimed the insulin drip was only indicated if the patient's condition was deteriorating despite other supportive measures. Respondent claimed, and the record supports, that Patient B's blood pressure was declining and therefore Respondent chose to implement Poison Control's recommendation to start an insulin drip. The Committee finds that the insulin drip was medically indicated and resulted from appropriate consultation therefore the Department did not prove this factual allegation. [Ex 5, p 9; Ex B; Ex C; Ex G; Ex H; T 108-109, 358-359]

The Committee concludes that there are times when there is a clear indication for the physician to not follow Poison Control's recommendations but there was no evidence of that here. For this and the reasons stated above, the Committee unanimously concludes that the

Department did not prove either of the factual allegations regarding Patient B, therefore the Committee did not sustain those charges.

CONCLUSIONS OF LAW

Respondent is charged with two Specifications of Charges of professional misconduct under Educ. Law §6530. Because all factual allegations were dismissed by the Panel, there are no Specifications of Charges to consider therefore the Committee unanimously concludes that the First and Second Specifications are dismissed.

DISCUSSION

Credibility and Weight[5]

The Department presented one witness, Jeffrey L. Margulies, M.D., to testify as an expert witness. Respondent testified in his own behalf and presented one witness, Arnold James Ciaccio, M.D., to testify as an expert witness. Both Dr. Margulies and Dr. Ciaccio had the requisite experience and credentials to render expert opinions.

The Committee found Dr. Margulies' testimony to be confusing and not persuasive. The Committee felt Dr. Margulies did not offer a persuasive rationale as to why the EKG and Troponin tests should have been repeated in Patient A. The Panel was also concerned that Dr. Margulies seemed to be unaware that an NG tube could be used for both irrigation and aspiration or that insulin could be used for diabetes and calcium-channel blockers. The Committee did not give Dr. Margulies' testimony much weight in part because he seemed unsure of what authority he was using and in part because he did not provide the Panel with supporting evidence for many of his opinions or for the standard of care he was espousing. The Committee found Dr. Margulies' testimony that Respondent's care and treatment did not meet standards of care for

[5] *All findings in this section are unanimous.*

Patient B was not credible because he seemed to be confused about uses for an NG tube and insulin, and because he posited that text books in 2009 would have supported his opinions but then conceded that he hadn't read them recently.

The Committee found both Dr. Ciaccio's and Respondent's testimony to be credible. Respondent's testimony that he didn't remember Patient A was credible and did not detract from his explanations (which in part relied on his relaying what his standard practice is) regarding his care and treatment of this patient. The Panel believes that Patient A, who was "1,000s of patients ago for an ER physician" would not stick in an ER physician's mind because GI complaints are common in the ER and nothing bad happened to Patient A.

Additionally, the Committee found that Department's Exhibit 8 did not discredit Respondent's testimony. Exhibit 8 supports the Department's contention that OPMC (the Office of Professional Medical Conduct) sent Respondent the patients' records and the report of interview. But there was nothing in Exhibit 8 to support the Department's contention that Respondent was informed that he could have counsel present for the interview or that he could respond in writing to the report. In addition, nothing in Exhibit 8 addressed if Respondent indicated whether he was aware of Patient A's bloody diarrhea. All of these contentions were raised by the Department's attorney on cross examination, but these contentions were not supported by a witness giving sworn testimony or by documentation.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

Respondent's attorney argued that if the Department fails to meet its burden with respect to the Specifications, the charges must be dismissed and no disciplinary action may be imposed because the evidence would have demonstrated that Respondent was neither negligent nor incompetent with respect to both Patients. The Department argued that the charges should be

upheld and Respondent's license to practice medicine in New York State should be disciplined and sanctioned with a Censure and Reprimand.

Because no factual allegations or specifications of charges were sustained, they are dismissed and there will be no penalty or sanction.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Educ. Law §6530 are not sustained:

   Educ. Law §6530(3) – practicing with negligence on more than one occasion
   Educ. Law §6530(5) – practicing with incompetence on more than one occasion

2. This matter is **dismissed**.

3. This order shall be effective upon service on the Respondent by personal service or by certified mail as required under PHL §230(10)(h).

DATED: 12/15/14, New York
December , 2014

REDACTED

JOAN MARTINEZ-McNICHOLAS, Chair
ELISA J. WU, M.D.
JOEL M. ZINBERG, M.D.

To: Joel Abelove
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Rm 2512
Albany, New York 12237

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Sandeep K. Johar, D.O.
c/o James D. Lantier, Esq.
Smith Sovik Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
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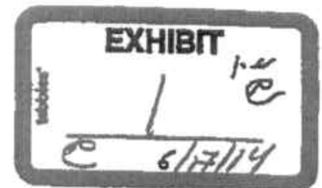
APPENDIX 1



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

IN THE MATTER OF SANDEEP K. JOHAR, D.O.	NOTICE OF HEARING

TO: Sandeep K. Johar, D.O. c/o James Lantier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, NY 13202

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 17, 2014, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, Hearing Room #1, New York, New York 10007, 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, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, 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.

DATE April 28, 2014
Albany, New York

REDACTED

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:
Joel E. Abelove, Associate Counsel

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

IN THE MATTER OF SANDEEP K. JOHAR, D.O.	STATEMENT OF CHARGES

SANDEEP K. JOHAR, D.O., the Respondent, was authorized to practice medicine in New York State on or about July 10, 2006, by the issuance of license number 240948 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or around September 9, 2009, Respondent provided medical care to Patient A, a 49-year-old male who presented to Faxton St. Luke's Healthcare Emergency Department, Utica, New York, complaining of abdominal pain, nausea, vomiting and bloody diarrhea. Respondent's care of Patient A deviated from acceptable standards in that he:

1. Failed to adequately review Patient A's earlier diagnostic test results;
2. Failed to perform appropriate reassessments of Patient A's ECG and Troponin; and/or
3. Discharged Patient A before adequate conclusion of his medical condition.

B. On or around April 13, 2009, Respondent provided medical care to Patient B, a 45-year-old female with a history of diabetes and hypertension, who presented to Faxton

St. Luke's Healthcare Emergency Department after taking a medication overdose. Respondent's care of Patient B deviated from acceptable standards in that he:

1. Inappropriately attempted to use a nasogastric tube on Patient B, unnecessarily increasing the risk of complications and morbidity; and/or

2. Used an insulin drip without adequate medical indication.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A and A.1, A and A.2, and/or A and A.3.

2. Paragraphs B and B.1 and/or B and B.2.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A and A.1, A and A.2, and/or A and A.3.

2. B and B.1 and/or B and B.2.

DATE: April 28, 2014
Albany, New York

REDACTED

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct