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HEALTH

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

Sue Kelly
Executive Deputy Commissioner

February 1, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
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Tariq Niaz Ahmad, M.D.
170 Rother Avenue
Buffalo, New York 14212

RE: In the Matter of Tariq Niaz Ahmad, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-13) 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 OF TARIQ NIAZ AHMAD, M.D.	DETERMINATION AND ORDER

BPMC #12-13

A Notice of Hearing and Statement of Charges, both dated April 28, 2011, were served upon the Respondent, **TARIQ NIAZ AHMAD, M.D.** **STEVEN V. GRABIEC, M.D.**, Chairperson, **SANFORD H. LEVY, M.D.** and **HENRY M. SLOMA**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10) 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 **TIMOTHY J. MAHAR, ESQ.**, of Counsel. The Respondent appeared by **ROACH, BROWN, McCARTHY & GRUBER, P.C., J. MARK GRUBER, ESQ.**, of Counsel. Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	April 18, 2011
Answer Filed:	May 3, 2011
Pre-Hearing Conference:	May 16, 2011
Hearing Dates:	May 25, 2011 July 20, 2011 July 21, 2011 October 14, 2011
Witnesses for Petitioner:	James Leyhane, M.D. Thomas Raab, M.D. Sevak Soukiazian, M.D. Maria Prior, R.N. Jacqueline Piotrowski, R.N. Linda Szefler
Witnesses for Respondent:	Tariq Niaz Ahmad, M.D.
Deliberations:	December 6, 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. Tariq Niaz Ahmad, M.D. ("Respondent") is charged with thirty-three

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 include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraud in the practice of medicine, making a false report, moral unfitness 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. TARIQ NIAZ AHMAD, M.D., the Respondent, was authorized to

practice medicine in New York State on November 29, 2002, by the issuance of license number 226999 by the New York State Education Department.

PATIENT A

2. On February 11, 2009 at 12:59 A.M., Patient A, then a 66 year-old male, was evaluated in the emergency department of Mercy Hospital of Buffalo, Buffalo, NY for complaints of shortness of breath (Ex. 3, p. 38; T. 24).

3. Among Patient A's out-patient medications was Coumadin, a blood thinner (T. 25).

4. A chest x-ray ordered by the emergency department showed, among other things, a large left pleural effusion or fluid on the left side (Ex. 3, p. 128; T. 26-27).

5. Patient A was admitted to Mercy Hospital under Respondent's care (Ex. 3, p. 29).

6. Patient A had a mechanical heart valve replacement (St. Jude valve) made of both metal and plastic (T. 30). The standard of care for managing patients with a mechanical heart valve replacement is treatment with Coumadin to prevent clots from forming on the valve which could shower up to the brain and cause a stroke (T. 30-31). This is a health risk specific to mechanical heart valves (T. 30). By thinning the blood, Coumadin prevents clot formation (T. 31).

7. On February 11, 2009 at 7:40 p.m., Patient A's INR was

reported by the lab as 1.4 (Ex. 3, p. 54; T. 32). The lab reported that, for patients who have mechanical valves in the mitral position, the acceptable range for the INR value is 2.5 to 3.5 (Ex. 3, p. 55; T. 33). Patient A's was outside the therapeutic range with an INR of 1.4 and was at risk for clot formation on the valve with the potential of a stroke (T. 33).

8. The standard of care for managing Patient A with an INR value of 1.4 was to elevate the INR to the 2.5 to 3.5 range using quick acting agents such as Lovenox (T. 34).

9. Respondent in his admission history and physical for Patient A documented the patient's INR of 1.4 and a treatment plan to continue Patient A on Lovenox at full dose until therapeutic (Ex. 3, p. 36; T. 35). Lovenox is a low molecular Heparin which acts very quickly, within minutes, to thin the blood (T. 35). In Patient A's case, Lovenox would protect Patient A from the valve clotting (T. 35).

10. Full dose Lovenox is one milligram of Lovenox per kilogram of body weight, given subcutaneous, twice a day (T. 35).

11. Respondent's admission orders for Patient A dated February 11, 2009, include an order for Lovenox at a dose of 40 milligrams, subcutaneously, twice a day (Ex. 3, p. 21; T. 36).

12. Patient A's body weight was documented in the hospital record as 85.927 kilograms (Ex. 3, p. 143). A full dose of Lovenox

for Patient A would have been 85 milligrams, subcutaneously, twice a day (T. 37).

13. The standard of care was for Respondent to give Patient A a full dose of Lovenox of 85 milligrams subcutaneously, twice a day (T. 37-38).

14. Respondent's order for 40 milligrams, subcutaneously, twice a day is a serious deviation from accepted standards of care (T. 38-39). Respondent's order provided less than half of a full treatment dose, and it placed Patient A at an increased risk of stroke due to clot formation (T. 30-39).

15. Respondent also ordered Coumadin and baby aspirin for Patient A; however, these medications in addition to the half-dose of Lovenox would have been insufficient to anticoagulate Patient A (Ex. 3, p. 21; T. 39). Coumadin would have eventually thinned the blood, but it takes a long time to act and build up in the body to the point that it could protect the valve (T. 39). Lovenox should be used until the INR reaches the 2.5 to 3.5 range (T. 39). Aspirin would not be a sufficient anti-coagulant to protect the heart valve (T. 39).

16. Respondent's failure to order full dose Lovenox between February 11, 2009 and February 15, 2009 for Patient A was a serious deviation from accepted standards of care (T. 47).

17. Patient A underwent a thoracostomy and chemical and mechanical pleurodesis on February 19, 2009 (Ex. 3, p. 89; T. 48-49).

The anesthesia record documents that after the procedure was completed, Patient A went into an abnormal heart rhythm (Ex. 3, p. 76; T. 48-50). The surgeon was called back into the room and a code was called (T. 50-51). Patient A could not be resuscitated and died (T. 50). Patient A suffered a large clot in the right ventricle (Ex. 3, p. 78; T. 51).

18. Respondent dictated a discharge summary for Patient A on March 18, 2009, 27 days after the patient's death on February 19, 2009 (Ex. 3, p. 4; T. 52-53). The discharge summary is to document, among other things, what transpired during the admission as well as the follow-up plans (T. 53).

19. Respondent documented in Patient A's discharge summary that Patient A underwent a thoracocentesis with an improvement in his symptoms (Ex. 3, p. 4). Respondent's description of Patient A as having improved following surgery was grossly inaccurate as Patient A had died in recovery (T. 53-54). Respondent further documented that Patient A was evaluated by cardiac thoracic surgery and was eventually discharged from the hospital with out-patient follow-up to home with services (T. 54). This statement was also grossly inaccurate, as Patient A was not discharged with out-patient follow-up (T. 54). Finally, Respondent documented fifteen discharge instructions for Patient A which were inappropriate in circumstances in which the patient had died during the admission.

20. Respondent's discharge summary for Patient A was a deviation from accepted standards of care (T. 54-55).

PATIENT B

21. Patient B, then 62 years old, was admitted to Mercy Hospital by Respondent on April 10, 2007 with a presenting complaint of altered mental status (Ex. 4, pp. 105-106; T. 70). Patient B had been bedbound for two weeks and had recurrent falls in the several days prior to admission (Ex. 4, p. 105).

22. Respondent's impression following his examination of Patient B was an apparent "abdominal catastrophe with leukocytosis, abdominal tenderness and abnormal liver function tests consistent with liver shock" (Ex. 4, p. 106; T. 72). Liver shock describes a condition in which the liver is not receiving enough blood flow and is damaged (T. 72).

23. Respondent admitted Patient B to the ICU to be treated with IV Zosyn, a broad spectrum antibiotic (Ex. 4, p. 106; T. 71).

24. The standard of care requires an attending physician to evaluate a hospitalized patient daily, or more often if the patient's condition warrants further evaluation (T. 74).

25. Daily evaluation by the attending is required even if the patient is being followed by residents in the same specialty as the attending (T. 74-75). Residents are physicians in training and are not attending physicians (T. 75).

26. Daily evaluation by the attending is required even if the patient is being seen and evaluated by physicians in other medical specialties as these specialist physicians would be focused on their specific area of expertise in the patient's care (T. 75).

27. Daily evaluation by the attending is required even though there was a Do Not Resuscitate order in place for Patient B. Do Not Resuscitate does not mean that the patient is not to be treated (T. 75). Do Not Resuscitate means that the patient does not want to be resuscitated if his or her heart stops (T. 75).

28. It is the standard of care to document the findings and treatment plan from the attending physician's daily evaluation of a hospitalized patient (T. 76). Documentation communicates the attending's findings and plan to consulting physicians who exam the patient subsequent to that documentation (T. 76).

29. On April 25, 2007, the Case Manager of the CCU, Maureen O'Malley, informed Thomas Raab, M.D., the Chief of the Department of Medicine at Mercy Hospital that there were no progress notes from Respondent in the hospital record of Patient B for April 22, 2007, April 23, 2007 and April 24, 2007 (Ex. 5, p. 2). Dr. Raab personally reviewed Patient B's hospital record on April 25, 2007, and found no progress notes for any of those three dates (T. 410-412).

30. Respondent's failure to document an progress note for Patient B on April 22, 2007, April 23, 2007 and April 24, 2007 was on

each occasion a deviation from accepted standards of care (T. 77-78, 81, 87).

31. The standard of care for making late entries in the hospital record requires the medical practitioner to document the date on which the entry into the record is made or otherwise document an explanation as to why the progress note is being made at a later date (T. 81-82). The evaluation findings and treatment plan should be documented (T. 82).

32. The purpose of the standard for making a late entry to the medical record is to maintain the proper chronology of the hospital record and to explain why a late entry is being made to the record (T. 82).

33. Dr. Raab again reviewed Patient B's hospital record during the first week of June, 2007 (Ex. 5, p. 2). At the time of his review in June, Dr. Raab found progress notes from Respondent for April 23, 2007 and April 24, 2007, which had not been present at the time he reviewed Patient B's record on April 25, 2007 (Ex. 5, p. 2; T. 414-416).

34. Respondent backdated these two progress notes in Patient B's hospital record. The progress note dated "4/23/07" by Respondent was made after April 25, 2007 (Ex. 4, p. 225; Ex. 5, pp. 2, 39; T. 414).

35. Respondent's failure to document the correct date on which

Respondent's progress note of April 23, 2007 was entered into the record was a deviation from accepted standards of care (T. 84). It was an inaccurate representation of when the note was made (T. 84). Respondent wrote an undated progress note in Patient B's hospital record between a resident's progress note dated 4/24/07 and a nurse's note, also dated 4/24/07 (Ex. 4, p. 230). Respondent wrote this undated progress note after April 25, 2007(T. 415-416).

36. Respondent's progress note on page 230 of Patient B's hospital record (Exhibit 4) which appears between a resident's progress note dated April 24, 2007 and a nurse's note dated April 24, 2007 inaccurately represents the date of its entry into the patient's record. Respondent's failure to document the correct date on which his progress note which appears on page 230 of Exhibit 4 was entered into the record after April 25, 2007 was a deviation from accepted standards of care (T. 87-88).

PATIENT C

37. Patient C, then 68 years old, was seen in the emergency department of Mercy Hospital on June 20, 2008 complaining of difficulty breathing (Ex. 6, p. 44; T. 101-102).

38. Patient C's home medications included the cholesterol medications Zetia and Crestor, and a blood thinner, warfarin, which is Coumadin (Ex. 6, p. 44; T. 102).

39. Patient C, who has chronic atrial fibrillation, was

administered Coumadin (5 mg) and Lovenox (120 mg) in the emergency department (Ex. 6, p. 46; T. 103-104). Patient C was admitted from the emergency department for telemetry observation by Respondent (Ex. 6, p. 46; T. 104). The diagnosis of the emergency department physician was chest pain and dyspnea (Ex. 6, p. 46).

40. Respondent gave admission orders concerning Patient C's diabetes, congestive heart failure and other medications (Ex. 6, pp. 10-14; T. 104-105). Respondent further wrote Patient C's discharge summary when the patient was discharged from Mercy Hospital on June 23, 2008 (Ex. 6, p. 9; T. 106). Respondent listed himself as the attending physician on the discharge summary for Patient C.

41. Patient C has a history of atrial fibrillation, a condition in which the upper chambers of the heart quiver in place rather than pump blood (Ex. 6, p. 31; T. 111-112).

42. Patient C's atrial fibrillation was managed as an outpatient by treatment with warfarin, which is Coumadin (Ex. 6, p. 30; T. 112-113). Warfarin reduces the risk of stroke in a patient with atrial fibrillation.

43. Patient C has a history of dyslipidemia or high cholesterol (Ex. 6, p. 31; T. 113).

44. The emergency department record for Patient C included multiple references to Patient C's outpatient treatment with warfarin (Ex. 6, pp. 35, 37, 44; T. 113-114). It is the standard of care for a

patient's attending physician to review the emergency department record (T. 114).

45. It is the standard of care to continue during a hospital admission to treat a patient with atrial fibrillation with warfarin in order to lower the risk of stroke unless there is a reason not to continue that treatment (T. 115).

46. On June 20, 2008, during Patient C's hospital admission, his INR was measured at 1.1, a value below the therapeutic range for patients with a history of atrial fibrillation (INR 2.0 to 3.0) (Ex. 6, p. 70; T. 115-116).

47. With an INR of 1.1, Patient C was not adequately prophylaxed against stroke as his blood was too thick (T. 116).

48. Respondent failed to order any anticoagulation therapy for Patient C during the hospital admission (Ex. 6, pp. 83-96; T. 116-117). While Patient C did receive aspirin; aspirin would not be adequate to manage Patient C's atrial fibrillation (T. 117).

49. Patient C did not receive any type of evaluation or treatment during his admission which would have required that anticoagulation therapy be stopped (T. 118). Further, no medical consultant either requested or ordered that anticoagulation therapy be stopped for Patient C (T. 118).

50. Respondent's failure to order anticoagulation therapy for Patient C during the hospital admission was a deviation from the

standards of care as it placed Patient C at increased risk for stroke (T. 118).

51. Respondent's discharge instructions to Patient C included a direction to follow up with his primary care physician in one to two weeks (Ex. 6, p. 4; T. 118-119).

52. Respondent failed to order adequate anticoagulation therapy for Patient C at the time of discharge (Ex. 6, p. 6; T. 119). Respondent did order aspirin for Patient C at discharge; however, aspirin alone would not provide adequate anticoagulation for Patient C (T. 119).

53. Respondent's failure to order adequate anticoagulation medication for Patient C at the time of discharge was a deviation from accepted standards of care due to Patient C's increased risk of stroke (T. 119-120). A reasonably competent hospitalist would recognize the indications for ordering adequate anticoagulation therapy for Patient C at the time of his discharge from the hospital (T. 120-121).

54. Patient C has a history of diabetes (Ex. 6, p. 4; T. 121). At discharge, Respondent ordered the drug Avandamet for Patient C which is a combination of the drugs Avandia and Metformin (Ex. 6, p. 6; T. 121).

55. During his hospital admission, Patient C had an abnormal creatinine level of 1.7 on June 20, 2008, a normal creatinine level

of 1.5 on June 21, 2008, and an abnormal creatinine level of 1.8 on June 22, 2008 (Ex. 6, pp. 71 and 75; T. 121-122).

56. On June 20, 2008, Patient C had a CT of the chest with contrast to rule out a pulmonary embolism (Ex. 6, p. 79; T. 122-123). The contrast used in CT studies is well known to cause elevation in a patient's creatinine level (T. 123).

57. The manufacturer of Metformin states that the drug is contraindicated for patients with creatinine values greater than 1.5 (T. 123). A rare but potentially lethal side effect of Metformin is lactic acidosis, a condition which causes the patient's body to become very acidic (T. 123-124). Should acidity at that level occur, mortality rates are 50 percent (T. 124).

58. The contraindication of Metformin for patients with elevated creatinine levels, particularly a diabetic patient, is very well known among hospitalists and physicians who practice internal medicine (T. 124).

59. Respondent's prescription of Metformin to Patient C at the time of his discharge from Mercy Hospital was a deviation from accepted standards of care as it placed Patient C at increased risk for lactic acidosis given his elevated creatinine levels (T. 124).

60. Patient C had a history of high cholesterol or dyslipidemia and prior to Respondent's medical care had been prescribed cholesterol lowering medications as an outpatient (Ex. 6, p. 31; T.

113). The standard of care would have been for Respondent to continue Patient C's cholesterol lowering medications, Crestor and Zetia, at discharge due to the patient's condition of hyperlipidemia, unless there was an indication not to continue these medications (T. 124-125).

61. Respondent's failure to restart Patient C on Crestor or Zetia at the time of his discharge from Mercy Hospital was a deviation from accepted standards of care (T. 125-126). A reasonably competent physician would understand the indications for restarting these medications for Patient C at the time of discharge (T. 126).

62. Respondent failed to document in Patient C's discharge summary Patient C's evaluation for pulmonary embolism and lab findings consistent with anemia (Ex. 4, p. 4, 69; T. 126-127). The standards of care required Respondent to document in the discharge summary both the evaluation for a pulmonary embolism and impression of anemia so that Patient C's primary care physician would know to follow up on these conditions in caring for Patient C as an outpatient (T. 127). Respondent's failure to document Patient C's evaluation for pulmonary embolism and the impression of anemia for the purposes of postadmission follow-up was a deviation from accepted standards of care (T. 127-128).

PATIENT D

63. Patient D was a 57 year-old female when she was seen in the

Mercy Hospital Emergency Department on June 14, 2008 for complaints of chest pain in the mid sternal area, which Patient D rated as a 10/10 on a pain scale (Ex. 7, p. 11; T. 153). The pain was ongoing in the emergency department (T. 153).

64. Patient D was admitted by Respondent for 23 hours observation with a diagnosis of chest pain (Ex. 7, pp. 8, 9, 13; T. 155).

65. Respondent ordered an EKG for Patient D for the following morning (Ex. 7, p. 9; T. 156). Respondent also ordered a cardiology consultation (Ex. 7, p. 9; T. 156).

66. Patient D remained in the emergency department after her admission by Respondent, and Respondent, as her attending physician, was responsible for Patient D's ongoing care (T. 157).

67. At 11:23 PM on June 14, 2007, Patient D suddenly complained of 10 out of 10 chest pain and an EKG was ordered by the emergency department physician (Ex. 7, p. 25; T. 157-158). The emergency department physician reviewed the EKG and ordered Patient D to higher monitoring (telemetry II) (Ex. 8, p. 11; T. 156). The emergency department physician conferred with Respondent at 12:49 AM on June 15, 2007 (Ex. 8, p. 11). Patient D's chest pain was a change in her condition and would be basis for the emergency department to contact Respondent (T. 158-159).

68. A CT of the chest was ordered at 1:19 AM (Ex. 7, p. 18). A

stat preliminary radiology report was sent to the Emergency Department by 2:33 AM (Ex. 7, pp. 60-61). Radiology reported that the chest CT showed large pulmonary emboli, or clots, on both sides of the lungs (Ex. 7, pp. 60-61; T. 161). The condition was life-threatening (T. 161).

69. The radiology report of life-threatening pulmonary emboli provided a reason for the emergency department to report this change in condition to Respondent, the patient's attending physician (T. 163).

70. The emergency department Secretary, Linda Szelfer, was instructed to contact Respondent so that the emergency department physician, Dr. Bukhari, could consult with him regarding Patient D (T. 478). Ms. Szelfer called Respondent at 3:01, 3:43, 3:50, 3:56, 4:02 and 4:25 on June 15, 2007 (Ex. 8, p. 11; T. 478-482). Respondent did not answer his phone on any of these six occasions and a message was left for Respondent to call Mercy Hospital and a phone number was given on each occasion (T. 478). During this sequence of times, Dr. Bukhari had asked Ms. Szelfer to call Respondent again at 3:43 AM when Respondent failed to return the call made at 3:01 AM (T. 479). When Respondent failed to respond to the message left at 3:43 to call back, a nurse in the emergency department requested that calls continue to Respondent until he responded (T. 480). At that time there was a lot of commotion in the emergency department relating to

Patient D who went into cardiac arrest and coded three times between 3:45 AM and 4:51 AM (T. 165-166, 480; Ex. 7, pp. 44-45). Ms. Szelfer left a message each time requesting Respondent to contact the emergency department (T. 478-482). The code was managed by Michael Merrill, M.D., a physician with an in-house hospitalist group, who had been contacted by the emergency department to assist in Patient D's care (Ex. 7, p. 47). At 4:26 AM Respondent phoned the emergency department and initially spoke to Ms. Szelfer. A comment was made as to why there were so many calls to Respondent's phone (T. 482). Ms. Szelfer transferred Respondent to Dr. Bukhari, the emergency department physician (T. 482).

71. Patient D died at 4:51 AM (Ex. 7, pp. 44-45; T. 165-166).

72. The standard of care requires an attending physician to respond to the hospital within 30 minutes of being contacted by telephone (T. 163). Hospitalist tend to care for sicker patients and need to be reachable by the hospital (T. 163-164). Respondent's failure to respond to six calls from the emergency department regarding Patient D between 3:01 AM and 4:25 AM before responding at 4:26 AM was a deviation from accepted standards of care (T. 164-165).

73. Respondent was not reachable for nearly 90 minutes and responded only after multiple contacts from the emergency department (T. 165).

PATIENT E

74. Patient E, then 85 years-old, was a resident of the Absolut Center for Nursing and Rehabilitation Center in September, 2008 (Ex. 9, p. 94). On September 8, 2008, the nursing staff noted that Patient E's right knee was swollen (Ex. 9, p. 94; T. 184-185). Nursing contacted Respondent on September 8, 2008, and Respondent ordered laboratory studies and a baseline x-ray of Patient E's right knee (T. 94). The lab findings were reported to Respondent at 7:00 PM on September 8, 2008 (Ex. 9, p. 94).

75. At 8:00 PM on September 8, 2008, nursing was informed by the radiology group interpreting the x-rays that there was a "possible/questionable distal femur fracture of the right knee (RLE), radiologist recommends oblique views be taken" (Ex. 9, pp. 94-95). Nursing called Respondent at 8:00 PM on September 8, 2008 and documented that they were awaiting his return call (Ex. 9, p. 95).

76. At 10:00 PM on September 8, 2008, nursing documented that aspirin given to Patient E had little effect on the discomfort in her right knee, and that the knee was warm with edema (Ex. 9, p. 95). Nursing further documented that they were awaiting Respondent to return calls with new orders (Ex. 9, p. 95).

77. Respondent called nursing at 5:30 PM on September 11, 2008 and ordered, among other things, oblique x-ray views of the knee (Ex. 9, p. 96). At 6:00 PM on September 11, 2008, Respondent came to the

nursing facility to evaluate Patient E and transferred her to Mercy Hospital for joint aspiration to rule out a septic knee (Ex. 9, p. 49, 97). A diagnosis of a right knee fracture was subsequently reported to the nursing facility (Ex. 9, p. 97 9/12/08, 3 PM; p. 98 9/13/08, 4 AM).

78. The standard of care is for an attending physician to respond to a call from a nursing home in a timely manner (T. 185-186). Respondent was initially contacted at 8:00 PM on September 8, 2008 to request orders for additional x-rays of Patient E's knee on the recommendation of radiology. Respondent did not respond for approximately 69 hours, until 5:30 PM on September 11, 2008 at which time he ordered the requested x-rays. Respondent's delay in responding to the request for further x-rays was a deviation from accepted standards of care (T. 189). Patient E had a leg fractured which went undiagnosed due to Respondent's delayed response (T. 189).

PATIENT F

79. Patient F, then 94 years old, was admitted by Respondent to Mercy Hospital on April 1, 2006 for chest pain from the previous evening (Ex. 10, p. 36).

80. The ambulance record documented that Patient F had an allergy to Cardizem (Ex. 10, p. 205). The Mercy Hospital Emergency Department record documented under "allergens" that in 1996 Patient F had a rash after taking Cardizem (Ex. 10, p. 36). Cardizem is a drug

used to slow the rate of atrial fibrillation (T. 197-198). It is also used in the treatment of high blood pressure (T. 197-198).

81. In another portion of the emergency department record a "possible" allergy to Cardizem is reported, while a cardiology note completed by a nurse practitioner documented that Patient F suffers a severe rash from Cardizem (T. 199).

82. Respondent documented a history and physical examination of Patient F on April 1, 2006 (Ex. 10, pp. 46-47). The standard of care is that the medical history taken from a patient include the patient's history of allergies (T. 202). Respondent's history of Patient F documented that Patient F had no allergies (Ex. 10, p. 46).

83. Respondent's failure to obtain a history regarding Patient F's allergy to Cardizem was a deviation from the accepted standards of care (T. 202). Further, it was Respondent's responsibility to review Patient F's emergency department record including the documentation in the emergency department record of her allergy to Cardizem (T. 202-203). As the attending physician, Respondent would be writing the orders for Patient F and therefore, it is the standard of care for him to record the history of allergies even though other medical providers document it in other parts of the record (T. 204-205).

84. Cardizem is used in the treatment of atrial fibrillation (T. 201). It was documented in Patient F's hospital record that she

had previously developed a severe rash in response to Cardizem (T. 203). There was a risk that further exposure to the allergen could cause a more severe reaction such as anaphylaxis or respiratory arrest (T. 203).

85. Nine days into Patient F's admission, on April 9, 2006, and the day prior to the patient's discharge, Respondent recorded in a progress note that Patient F had an allergy to Cardizem (Ex. 10, p. 14). The history obtained by Respondent relating to Cardizem on April 9, 2006 was not timely and did not meet the accepted standards of care (T. 204).

86. The transfer summary which Respondent dictated at the time of Patient F's discharge failed to document an impression of atrial fibrillation (Ex. 10, pp. 4-5; T. 206). It was the standard of care to document the impression of atrial fibrillation in the discharge summary to notify the patient's out-patient medical providers of the condition (T. 206). Respondent's failure to document in the discharge summary the evaluation and impression of atrial fibrillation was a deviation from the standard of care (T. 207). Further, although Respondent was to care for Patient F as an out-patient, the standard of care required documentation of the condition of atrial fibrillation so as to notify other members of Patient F's health care team of the condition (T. 207).

PATIENT G

87. Patient G was 47 years of age on June 9, 2007 when he was evaluated in the emergency department of Mercy Hospital for chest pain radiating to his left arm (Ex. 11, p. 34). Patient G had been released from Mercy Hospital two days earlier after being diagnosed with a myocardial infarction which was treated by the placement of cardiac stents in the coronary arteries (Ex. 4, pp. 24, 34; T. 251-252). Respondent cared for Patient G during this earlier admission to Mercy Hospital (Ex. 11, p. 31).

88. Patient G's description of his current chest pain as similar to his chest pain at the time of his myocardial infarction was significant to Dr. Soukiazian as an indication of a current myocardial infarction (T. 374). Further, Dr. Soukiazian considered Patient G to be a high risk patient as he had a myocardial infarction in the last week with stent placement (T. 375). In Dr. Soukiazian's opinion, Patient G required evaluation by a cardiologist regarding the functioning of the stent (T. 375-376).

89. After an EKG was performed on Patient G in the ED, a call was placed to Dr. Emerson, who had performed Patient G's recent stent procedure (Ex. 11, p. 40; T. 376-377). However, Dr. Emerson, a cardiologist, was not on call that day; and Thomas Smith, M.D., the cardiologist on-call, returned the phone call (T. 376-378). Dr. Soukiazian presented Patient G's case to Dr. Smith over the telephone, including the current chest pain, and prior MI with stent

placement (T. 378). Dr. Soukiazian suggested to Dr. Smith that Patient G needed hospital observation or admission (T. 378). Dr. Smith agreed with this judgment and Dr. Soukiazian told Dr. Smith that he would call the hospitalist to admit Patient G (T. 378).

90. Dr. Soukiazian called Respondent by telephone to admit Patient G for 23-hour observation in a telemetry unit (T. 378-379). They spoke at approximately 6:25 PM (T. 381). Under hospital policy, as Respondent had cared for Patient G in the last 30 days, Respondent was to care for Patient G on readmission (T. 378-380).

91. In response to Dr. Soukiazian's recommendation to observe Patient G in telemetry for 23 hours, Respondent stated that he knew Patient G and that the patient should be sent home (T. 380). Respondent stated to Dr. Soukiazian that he did not feel Patient G's pain was cardiac pain (T. 380).

92. Dr. Soukiazian told Respondent that his recommendation was that Patient G required observations for 23 hours and that if Respondent did not want to admit Patient G, he (Respondent) should come to the ED and see the patient (T. 381).

93. Dr. Soukiazian spoke to Dr. Smith a second time (T. 386). Dr. Smith told Dr. Soukiazain to go with his (Soukiazian's) judgment regarding admission (T. 386).

94. Dr. Soukiazian spoke to Respondent a second time on the phone at 10:13 PM (T. 388). Between his first phone call with

Respondent at approximately 6:25 PM and the second call at 10:13 PM, Dr. Soukizian saw Respondent in the ED (T. 388-389). Respondent was sitting in the ED, and Dr. Soukiazian approached him and asked him to please see the patient (T. 389). Respondent did not respond to Dr. Soukiazian and left the ED (T. 389). Dr. Soukizian followed Respondent down the hall and again asked him to please see the patient for disposition, to make sure Respondent had heard him (T. 389). Respondent did not respond to Dr. Soukiazian (T. 389).

95. Dr. Soukiazian spoke to Respondent by telephone at approximately 10:13 PM after waiting approximately one hour and 30 minutes for Respondent to return the phone call to the ED (Ex. 11, p. 38; T. 390). Dr. Soukiazian told Respondent that Patient G needed to be seen or admitted for observation (T. 390-391). Respondent told Dr. Soukiazian to "Back off" and hung up the phone (Ex. 11, p. 38; T. 390-391).

96. The standard of care in circumstances in which an ED physician recommends to an attending physician the admission of an ED patient but the attending physician desires the patient discharged, is for the attending physician either to admit the patient or come to the ED, evaluate the patient and discharge the patient, if indicated (T. 271, 273). Given that the ED physician has evaluated the patient for his or her present complaints and the attending physician has not, the attending physician is required to evaluate the patient

prior to discharge or agree to the admission (T. 273-274).

97. Respondent's order to discharge Patient G from the ED without evaluating him was a deviation from standards of care given Dr. Soukiazian's recommendation for his admission (T. 274-275).

98. The ED call log for Patient G indicates that Respondent was called by the ED at 8:50 PM (Ex. 25, p. 3). This would be the second call to Respondent by Dr. Soukiazian after they had spoken at 6:25 PM. One hour later at 9:50 PM, Respondent was called again as he had not responded at 8:50 PM (Ex. 25, p. 3). Respondent did not return the ED's phone call until 10:13 PM, or 1 hour and 23 minutes after the call was placed (T. 277).

99. Respondent's delay in returning the phone call to the ED for 1 hour and 23 minutes was a deviation from accepted standards of care (T. 278). The policy and procedures of the Department of Medicine at Mercy Hospital require attendings to return calls to the ED within 30 minutes (Ex. 16, p. 6).

100. Respondent deviated from accepted standards of care in hanging up the telephone when consulting with Dr. Soukiazian at approximately 10:13 PM regarding the admission of Patient G (T. 278). Respondent's behavior was unprofessional and created an element of risk for Patient G insofar as Dr. Soukiazian would not know if Respondent was going to assume the care of Patient G or whether he would come to the ED to evaluate Patient G (T. 278-279).

101. Respondent deviated from accepted standards of care when he failed to respond to Dr. Soukiazian in the ED after Dr. Soukiazian had requested Respondent in person to evaluate Patient G and then left the ED without evaluating Patient G (T. 279-280).

102. At 11:00 PM on June 9, 2007, Respondent gave verbal orders to admit Patient G for 23 hours observation to the telemetry unit under the diagnosis of unstable angina (Ex. 11, p. 14). Among Respondent's orders were for Dr. Smith, a cardiologist, to evaluate Patient G (Ex. 11, p. 14). Respondent admitted Patient G approximately 4.5 hours after he first spoke with Dr. Soukiazian regarding admission (T. 281). This delay by Respondent in the disposition of a patient with chest pain deviated from accepted standards of care (T. 281-282).

103. At 11:40 PM on June 9, 2007, Patient G terminated his care with Respondent and continued his care at Mercy Hospital under another hospitalist group (Ex. 11, p. 98).

PATIENT H

104. Patient H, then 73 years old, was discharged from Mercy Hospital on December 22, 2006 following a three day admission, with the diagnoses of enlarged prostate, bilateral hydronephrosis and small bowel ileus, among other conditions (Ex. 12, p. 4; T. 306, 307). Respondent was Patient H's attending physician during the admission (Ex. 12, p. 4; T. 306).

105. Patient H was readmitted to Mercy Hospital on Respondent's service one day after his discharge, on December 23, 2006, after presenting in the emergency department at 5:55 AM with complaints of nausea and vomiting since 6:00 PM the previous evening (Ex. 13, p. 59, 61; T. 308).

106. Respondent performed an abdominal examination on Patient H on December 23, 2006 and noted that the abdomen was significantly more distended (Ex. 13, p. 68; T. 311). Respondent documented that a nasogastric tube would be held and that the Patient H probably would need a colonoscopy (Ex. 13, p. 68).

107. At 8:50 PM on December 23, 2006, Maria Prior, RN documented that Patient H's oxygen saturation rate on room air was 66%, but increased to 98% with an oxygen mask on (Ex. 13, p. 174; T. 312-313, 487-488). A pulse oxygen level of 66% on room air is low and indicates that the patient is having difficulty getting oxygen into his body (T. 313-314). Nurse Prior, believing Patient H to be in trouble, contacted the in-house physician, David Kupkowski, M.D., of the Aurora Hospitalist Group, regarding Patient H's respiratory distress (Ex. 13, p. 174; T. 487-488). Dr. Kupkowski evaluated Patient H at 8:55 PM and documented an impression of dyspnea secondary to congestive heart failure, pulmonary edema, and volume overload (Ex. 13, pp. 68-69; T. 314-315).

108. At 10:00 PM, Dr. Kupkowski spoke with Respondent regarding

Patient H (Ex. 13, p. 175; T. 318).

109. At 10:00 PM, Respondent ordered, by telephone, laboratory studies for Patient H to be conducted in the morning, including a CBC with differential, a comprehensive metabolic panel, chest x-ray, arterial blood gas, and fluid monitoring (Ex. 13, p. 25).

110. The BNP test ordered by Dr. Kupkowski is used in the evaluation of congestive heart failure (Ex. 13, p. 119; T. 320). Patient H's BNP level was measured at 413 which suggests an element of congestive heart failure (T. 321).

111. Patient H's complete blood count ordered by Dr. Kupkowski was significant for a white blood count of 2.3 which was low and may have suggested infection or that Patient H's organs were under increased stress (Ex. 13, p. 107; T. 321). Patient H's white blood count had been 7.6 at 5:15 AM, which was in the normal range (Ex. 13, p. 107; T. 321).

112. The D-dimer was measured at greater than 5,000 and was only significant in that it did not rule out the presence of a blood clot (Ex. 13, p. 108; T. 321).

113. At 11:30 PM these lab findings were reported to Dr. Kupkowski (Ex. 13, p. 175; T. 322-323). Dr. Kupkowski ordered heparin, a blood thinner (Ex. 13, p. 23). This order suggested that Dr. Kupkowski was treating Patient H as if he had a blood clot in the lung (T. 323). Further, Dr. Kupkowski ordered a VQ scan for the

following day to rule out a pulmonary embolus (Ex. 13, p. 23; T. 323).

114. At 11:30 PM, Dr. Kupkowski also ordered nursing to update Respondent regarding Patient H (Ex. 13, p. 23; T. 323-324, 491-492).

115. Maria Prior, RN, telephoned Respondent at 11:35 PM on December 23, 2006 for the purpose of updating him as to Patient H, as ordered by Dr. Kupkowski (Ex. 13, pp. 23, 175; T. 493-494). Respondent refused to listen to the update regarding Patient H, and told Nurse Prior that he would discuss the matter in the morning (Ex. 13, p. 175; T. 494). Respondent then hung up the telephone on Nurse Prior (Ex. 13, p. 175; T. 494-495).

116. As Patient H's attending physician, the standard of care was for Respondent to listen to the update regarding Patient H's condition (T. 325). Respondent's failure to receive the update from the nursing staff at approximately 11:30 PM on December 23, 2006 was a serious deviation from accepted standards of care (T. 325-326). If the attending physician is not aware of the patient's condition, it can result in patient harm (T. 326). Further, as there had been a sudden change in Patient H's condition, it was not an acceptable alternative for Respondent to direct that the report be delayed until morning (T. 326).

117. After Respondent's refusal to receive the update regarding Patient H, Nurse Prior spoke with Patient H's family regarding the

change in his condition (Ex. 13, p. 175; T. 495). At that time, Patient H's family notified Nurse Prior of the family's intention to transfer Patient H's care from Respondent to the Aurora Hospitalist Group (Ex. 13, p. 175; T. 495). Nurse Prior advised the Aurora Hospitalist Group of the family's intentions regarding the transfer of care (Ex. 13, p. 175; T. 496-497). Respondent's service was notified of the transfer at 6:30 AM on December 24, 2006 (Ex. 13, p. 176; T. 497).

118. Patient H was transferred to the ICU at 4:45 AM on December 24, 2006 (Ex. 13, p. 22). Patient H underwent an exploratory laparotomy on December 25, 2006 and was found to have gangrene of the small bowel and large intestine before the surgery was halted (Ex. 13, p. 95). Patient H died later in the day on December 25, 2006 after having been made comfort care (T. 329).

PATIENT I

119. Patient I, then 57 years old, was admitted to Mercy Hospital by Respondent on April 3, 2007, after being evaluated and treated in the emergency department for cellulitis and vascular insufficiency of both legs (Ex. 14, p. 42). Patient I, who had not seen a physician in 50 years, had weeping legs for 13 years with the condition having become worse in the last 3 months (Ex. 14, p. 42). The emergency department examination found large leg ulcers with purulent exudate, in addition to swelling, chronic edema and skin

induration (Ex. 14, p. 43; T. 341).

120. Respondent's admission history and physical exam of Patient I noted, among other things, fever, and gross, weeping leg ulcers (Ex. 14, pp. 40-41). Respondent treated Patient I with IV antibiotics, starting with Unasyn and subsequently changing to Zosyn (Ex. 14, pp. 14, 40; T. 343-344).

121. On April 7, 2007, the fifth day of Patient I's admission, IV access was lost and Patient I refused to have the IV restarted (Ex. 14, p. 149; T. 345). In the same note, nursing documented that a call was placed to Respondent for oral antibiotics.

122. At 9:30 PM on April 7, 2007, a registered nurse documented the following progress note: Call placed to Dr. Ahmad concerning ABX [antibiotics] treatment since pt [patient] refused to have IV re-inserted. Asked Dr. Ahmad if he wanted PO [oral] ABX [antibiotics] started and he offered no new order. (Ex. 14, p. 68)

123. Respondent initialed the voice order he gave to nursing which documented that Respondent gave no new orders for antibiotics after nursing had called him regarding Patient I's refusal to have the IV re-inserted (Ex. 14, p. 11).

124. A nursing note entered at 8:00 AM on April 8, 2007, documents that Patient I did not have the IV restarted, but wanted oral antibiotics (Ex. 14, p. 189). When IV access was lost and Patient I refused re-insertion of the IV, the standard of care was to

treat Patient I with oral antibiotics (T. 352). Oral antibiotics were indicated in order to continue to treat Patient I's infection (T. 352).

125. Respondent failed to order oral antibiotics for Patient I after IV access had been lost (T. 353). Respondent's failure to order oral antibiotics for Patient I after IV access had been lost was a deviation from accepted standards of care (T. 353).

126. Respondent entered a progress note in Patient I's hospital chart more than a month after her death in which he documented that Patient I's death was "secondary to noncompliance" (Ex. 14, p. 74).

127. Respondent's documentation as to the cause of Patient I's death as secondary to noncompliance does not meet accepted standards of care (T. 355-356). The cause of a patient's death is a disease process (T. 356). Noncompliance with treatment recommendations is not a disease process.

128. Respondent documented in Patient I's death certificate that the immediate cause of death was pulseless electrical activity (PEA) as a consequence of noncompliance and refusing interventions (Ex. 14, p. 214). While listing the immediate cause of death as pulseless electrical activity met minimal standards of care, attributing that condition to noncompliance did not meet standards of care (T. 357).

CONCLUSIONS OF LAW

In his answer and his brief, Respondent claimed that the Department had unreasonably delayed its investigation and notice of this hearing. If Respondent wishes to pursue his claim of an unreasonable delay occurring prior to the hearing notice, he may do so in a proceeding pursuant to Article 78 of the CPLR; however, the Hearing Committee was instructed that it may neither sustain nor reject that claim.

Respondent is charged with thirty-three 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. 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). 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.

Fraudulent Practice requires a finding that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 AD2d 315. The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must state the inference it is drawing regarding knowledge and intent. Choudry, supra, at 894 citing Breslin. Fraudulent intent may be inferred from evidence that the licensee was aware of the true state of facts at the time the false responses were given. Saldanha v. DeBuono, 256 AD 2d 935. Fraudulent intent may be inferred from evidence that the licensee was aware of the state of facts at the time false responses were given. Saldanha, supra.

In addition, the Third Department has stated in Matter of

Patin v. State Board for Professional Medical Conduct (77 Ad2d 1211) that:

> Since inadequate medical records will support a finding of negligence where "there is a relationship between inadequate record keeping and patient treatment" [citations omitted], the scant nature of petitioner's records coupled with [an expert witness's] testimony regarding the import of the missing information provides an additional basis for sustaining the charge of negligence on more than one occasion [citations omitted].

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 James Leyhane, M.D. as an expert witness. Dr. Leyhane is board-certified in internal medicine. He has practiced as a hospitalist and is currently the Director of the hospitalist program at St. Joseph's Hospital in Syracuse, New York. The Hearing Committee found that Dr. Leyhane was very credible and gave his testimony great weight. He was knowledgeable and gave balanced thoughtful opinions.

The Department also presented the testimony of five fact witnesses: Dr. Thomas Raab, Dr. Sevak Soukiazian, Maria Prior, Jacqueline Piotrowski and Linda Szafler. The Hearing Committee determined that each one of these witnesses was credible.

The Respondent did not present testimony by an expert witness, but did testify on his own behalf. Respondent clearly has a stake in the outcome of these proceedings, and the Hearing Committee felt that his responses frequently lacked credibility. Although the Committee does understand that an individual can forget information over time, they felt that Respondent was selecting to say that he had no recall of certain events while on other occasions he stated a detailed recall of other events. The Hearing Committee concluded that Respondent's frequent claims of an inability to recall information were largely a strategy to avoid having to respond to a question which had been posed to him.

Patient A

Although Respondent's treatment plan on admission for Patient A included continuing the patient on Lovenox at full dose until therapeutic, Respondent verbally ordered that the patient receive less than half the required dose. Respondent then missed an opportunity to correct his initial error the following day when he failed to review the written documentation of his verbal order as required to meet the acceptable standard of care.

Respondent's explanation for his failure to order the proper dose of Lovenox is inconsistent with his documented statement in the medical record of Patient A. Respondent testified that he did not order a full dose of Lovenox because he was concerned that Patient A might have had a cardiac tamponade, but the record establishes that he had already ruled out a tamponade based on a negative CT.

From the moment that Respondent admitted Patient A to the hospital, he became responsible for the care that was provided to the patient. When Respondent became aware that Patient A's lab results indicated that his INR was outside the range for patients who have a mechanical valve in the mitral position, Respondent needed to elevate the patient's INR using a quick acting agent such as Lovenox to prevent a clot from forming on the valve which could move to the brain causing a stroke. Respondent's failure to order the correct amount of a quick acting anticoagulant placed Patient A at risk for a stroke. The Hearing Committee concluded that this negligent failure was a gross deviation from the accepted standard of care.

Although Patient A went into cardiac arrest and died following a surgery during this hospitalization, Respondent stated in his discharge summary that the patient improved following the surgery and was discharged home for outpatient care. Respondent admitted that his discharge summary was erroneous and attributed his error to

completing Patient A's chart with undue haste. Respondent's negligence in this instance did not cause any risk to the patient who was already deceased, but the Hearing Committee was gravely concerned with the potential for patient harm when a physician has committed such a flagrant error because of his undue haste. This conduct met both the definition of negligence and a failure to maintain an adequate patient record.

Patient B

Based upon the credible testimony of Dr. Raab, the Hearing Committee concluded that Respondent failed to enter a progress note into the medical record of Patient B on April 22, 23 and 24, 2007. Patient B was in the intensive care unit being treated for sepsis. Respondent may have been confused about his responsibility, but he clearly should have known that he was ultimately in charge of Patient B's care. As Patient B's attending physician, he was required to document his care of the patient every day throughout the hospitalization. His failure to do so was negligence on each of the three days charged.

On or after April 25, 2007, Respondent then entered a note dated April 23, and April 24 in Patient B's medical record. Although the Hearing Committee could have inferred that Respondent did not examine Patient B on the dates in question because he made no contemporaneous note it the patient's record, the Committee after

some discussion ultimately decided that they were not sufficiently persuaded that Respondent failed to examine the patient on the dates indicated. As such, the false representation made by the Respondent in Patient B's medical record was limited to his having backdated the April 23 and April 24 progress notes. The Committee determined that Respondent's failure to properly document his late entries in the medical record was a further example of his careless practice of medicine rather than a fraudulent act intended to deceive which evidenced moral unfitness as urged by the Department. His conduct was both negligent and a further example of his failure to maintain a patient record.

Patient C

The record for Patient C contained no evidence of an admission history, physical exam or progress notes by Respondent during the patient's four day admission. Although Respondent was charged with misconduct for failing to perform and document these actions, the Hearing Committee considered it as likely that a portion of Patient C's medical record was lost or misplaced. For example, the Hearing Committee noted that the second page of an echocardiogram was missing from the record of Patient A (Ex. 3, p. 106).

Respondent's care of Patient C during the hospitalization, however, was proven to meet the definition of negligence. During a hospitalization, the standard of care is for a physician to continue

to treat a patient with atrial fibrillation with warfarin in order to reduce the risk of stroke unless there is a reason not to continue that treatment. Patient C's INR measurement indicates that it fell below the therapeutic range for a patient with atrial fibrillation. Further, Respondent failed to order adequate anticoagulation therapy when he discharged the patient. Respondent's current claim that he made a medical judgment to discontinue the anticoagulation therapy after learning that Patient C's left ventricle ejection fraction was low normal is inconsistent with his discharge summary which makes no mention of an altered treatment plan. Although the Hearing Committee deemed this conduct to be negligent, it felt that it did not rise to the level of gross negligence as it did with Patient A who had a mechanical cardiac valve.

Respondent also was negligent in his care of Patient C in that he discharged the patient on Avandamet which is a combination of the drugs Avandia and Metformin. Respondent's prescription of Metformin for Patient C who had an elevated creatinine level and who was diabetic was a violation of the standard of care. Here too, the Committee determined that Respondent's misconduct did not rise to the level of gross negligence.

Respondent's failure to continue Patient C on the cholesterol lowering drugs which he had been prescribed as an outpatient absent an indication to discontinue them was also a

deviation from accepted standards of care. The Hearing Committee considered and rejected Respondent's contention that his discontinuance of medications was appropriate as an exercise of his independent medical judgment because Respondent failed to offer any possible basis for such a change.

Finally, the Hearing Committee determined that Respondent's failure to document in the discharge summary both Patient C's evaluation for pulmonary embolism and impression of anemia was negligent as well as a failure to maintain an adequate medical record.

Patient D

Respondent admitted Patient D to the hospital for 23 hours observation with a diagnosis of chest pain. She remained in the emergency department, but Respondent as her attending physician was responsible for her care. A CT of Patient D's chest showed large pulmonary emboli on both sides of her lungs which was life-threatening. Based upon the credible testimony of Linda Szelfer who was a secretary in the emergency department, the Hearing Committee found that Respondent failed to respond to calls and messages left for the Respondent six times between 3:01 a.m. and 4:25 a.m.

Although Respondent was not required to come to the hospital, the standard of care required him to respond in a timely manner to the hospital's call reporting a change in his patient's

condition. In this instance Respondent's failure to respond to the calls from the emergency department did not create any grave risk to the patient, but Respondent's conduct was not within the minimal accepted standard patient care. Accordingly, the Committee determined that Respondent's care of Patient D was negligent.

Patient E

The radiologist who interpreted an x-ray that Respondent had ordered of Patient E's knee reported to the patient's nursing facility that there was a possible femur fracture and recommended that oblique views be taken. The record indicates that Respondent did not return the call from nursing staff at the facility until 69 hours later. Although Respondent testified about having difficulty with calls to the nursing facility being properly transferred, Respondent was obligated to find some means of responding to a call from the nursing facility in a timely manner. The Hearing Committee determined that Respondent's failure to return the call regarding his patient in a timely manner constituted another instance of negligence.

Patient F

Even though Patient F's allergy to Cardizem was noted in both the EMS record and the triage portion of the emergency department record, Respondent failed to ascertain this information from the patient directly or through his review of the patient's

medical record until nine days into the hospital admission. The Hearing Committee determined that Respondent's failure to obtain and document this information constituted negligence and a failure to maintain an adequate record. The Committee however does not consider this particular instance serious, as the written records of the consultants on this case were inconsistent and at times incorrect as pertaining to the patient's allergy to diltiazem. Respondent's record for patient F was also inadequate in that he failed to document an impression of atrial fibrillation in the patient's discharge summary.

Patient G

Respondent cared for Patient G when he was treated for a myocardial infarction by the placement of cardiac stents in the coronary arteries. When Patient G returned to the hospital two days later with complaints of chest pain, the emergency department physician, Sevak Soukiazian, M.D., felt that the patient needed hospital observation or admission. Dr. Soukiazian testified credibly before the Hearing Committee regarding his interactions with Respondent regarding this patient on the date in question.

Dr. Soukiazian first spoke with Respondent about his assessment at 6:25 p.m. by telephone. Since Respondent disagreed with the emergency physician's assessment that the patient required observation or admission, Respondent was required to come into the

hospital to evaluate and discharge the patient. When Dr. Soukiazian saw Respondent in the emergency department later that evening, he approached and asked Respondent to see the patient, but Respondent made no response to the request and walked away. At approximately 10:13 p.m., Dr. Soukiazian again asked Respondent to see or admit Patient G. Respondent told Dr. Soukiazian to "Back off" and hung up the phone. It was not until 11:00 p.m. that Respondent called the emergency department and gave verbal orders to admit Patient G for 23 hours observation.

Respondent's four and a half hour delay in admitting this patient was negligent because it was a violation of the accepted standard of care. If Respondent as the attending physician disagreed with the emergency department's physician, Respondent was obligated to evaluate the patient himself in the emergency department and either admit or discharge the patient after that evaluation.

At 11:40 p.m. that same evening, Patient G's care was transferred to the in-house physician. Therefore, the Hearing Committee did not sustain the further factual allegation related to the patient's care beyond Respondent's failure to timely evaluate the patient when he was in disagreement with the emergency department physician's assessment.

Patient H

The Hearing Committee credited the testimony of Maria

Prior, R.N., to establish that Respondent was still Patient H's attending physician at 11:35 p.m. on the evening in question when Ms. Prior called to update Respondent on the patient's condition. Respondent refused to listen to the update, told Ms. Prior that he would discuss the matter in the morning, and then hung up the phone. Ms. Prior testimony was consistent with the medical record for Patient H.

The Hearing Committee found that Respondent's testimony claiming that Patient H had refused to allow Respondent to evaluate him and that the patient's family had discharged him prior to Ms. Prior's call was inconsistent and lacked credibility. Respondent admitted on cross examination that he deferred his evaluation when he first encountered the patient in the emergency department because the patient was either being worked up or in the process of transfer to a floor. Respondent further admitted that the only other time that he saw Patient H was when the patient was on his way to the bathroom so the examination did not occur. This second attempt at an evaluation can hardly be classified as the patient's refusal.

The Hearing Committee also found that Respondent's testimony claiming the patient's care had already been transferred when Ms. Prior called him was inconsistent and lacked credibility. For example, Respondent's verbal orders at 10:00 p.m. to have labs performed in the morning were consistent with Respondent's plan to

provide continued care, and not with transferring care of the patient as claimed by Respondent.

The Hearing Committee concluded that Respondent's failure to receive an update regarding Patient H constituted negligence.

Patient I

While in the hospital, Patient I's IV access was lost, and she refused to have the IV restarted. When a nurse asked whether he wanted oral antibiotics started, Respondent gave no new orders. Respondent's failure to prescribe oral antibiotics was a deviation from accepted standards of care, constituting negligence.

Respondent suggested that he may have been thinking that Patient I would have become angry and left the hospital if he had ordered oral antibiotics. The Hearing Committee found the Respondent's rationale to lack credibility. To the contrary, a nurse's note in the patient's medical record indicates that the patient wanted to receive oral antibiotics.

Respondent also failed to maintain an adequate record for Patient I who dies during this hospitalization. More than a month after Patient I's death, Respondent wrote a progress note stating that her death was "secondary to noncompliance." Documenting a patient's noncompliance as a cause of death does not meet an accepted standard of care because noncompliance with treatment recommendations is not a disease process. Further, Respondent inappropriately

attributed the patient's immediate cause of death on her death certificate to her noncompliance.

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 B - B.1	Sustained
Paragraph B - B.2	Sustained
Paragraph B - B.3	Sustained
Paragraph B - B.4	Sustained
Paragraph C - C.1	Not Sustained
Paragraph C - C.2	Sustained
Paragraph C - C.3	Sustained
Paragraph C - C.4	Sustained
Paragraph C - C.5	Sustained
Paragraph D - D.1	Sustained
Paragraph D - D.2	Not Sustained
Paragraph E - E.1	Sustained
Paragraph E - E.2	Withdrawn
Paragraph E - E.3	Not sustained
Paragraph F - F.1	Sustained
Paragraph F - F.2	Sustained
Paragraph G - G.1	Sustained
Paragraph G - G.2	Not Sustained
Paragraph G - G.3	Not Sustained
Paragraph G - G.4	Not Sustained
Paragraph G - G.5	Not Sustained
Paragraph H - H.1	Withdrawn
Paragraph H - H.2	Sustained
Paragraph H - H.3	Not Sustained

Paragraph I - I.1	Sustained
Paragraph I - I.2	Sustained
Paragraph I - I.3	Sustained

Specifications

The First through Eighth 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. As was discussed in detail above, the Hearing Committee found Respondent's treatment of Patient A was grossly negligent. His care of remainder of the patients, however, did not rise to the level of gross negligence. By a unanimous vote, the First Specification is Sustained, and the Second through Eighth Specifications are Dismissed.

The Ninth through Sixteenth Specifications charged Respondent with practicing with gross incompetence within the meaning of New York Education Law §6530(6). As was discussed in detail above, the Hearing Committee found Respondent's treatment of these patients were caused by his negligence rather than incompetence. By a unanimous vote, the Ninth through Sixteenth Specifications are Dismissed.

The Seventeenth Specification charged Respondent with practicing with incompetence on more than one occasion, in violation of New York Education Law §6530(5). As stated above, the Committee

concluded the record does not establish that Respondent's actions in regard to the allegations charged demonstrate incompetence. Accordingly, the Seventeenth Specification is Dismissed.

The Eighteenth 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 Eighteenth Specification is Sustained by a unanimous vote.

The Nineteenth and Twentieth Specifications charged Respondent with fraud in the practice of medicine, in violation of New York Education Law §6530(26). As stated above, the Committee concluded Respondent's late entries to the medical record of Patient B was another example of his negligent conduct rather than a fraudulent action. Accordingly, the Nineteenth and Twentieth Specifications are Dismissed.

The Twenty-first and Twenty-second Specifications charged Respondent with making a false report, in violation of New York Education Law §6530(26). As stated above, the Committee concluded Respondent's late entry in the chart of Patient B was a negligent conduct. Accordingly, the Twenty-first and Twenty-second Specifications are Dismissed.

The Twenty-third through Thirty-first Specifications

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 A, B, C, F and I were inadequate. Accordingly, the Twenty-third, Twenty-fourth, Twenty-fifth, Twenty-eighth and Thirty-first Specifications are Sustained; and the Twenty-sixth, Twenty-seventh, Twenty-ninth and Thirtieth Specifications are Dismissed.

The Thirty-second and Thirty-third Specifications charged the Respondent with moral unfitness. The Hearing Committee concluded that Respondent's late entries into Patient B's chart was evidence of his negligence and not moral unfitness. Accordingly, the Thirty-second and Thirty-third Specifications are Dismissed.

DETERMINATION AS TO PENALTY

Although the Department recommended that Respondent's license to practice medicine be revoked, the Hearing Committee felt that Respondent displayed a significant amount of medical knowledge and some potential for rehabilitation during his testimony. The Committee, however, is mindful of the need to ensure the safety of the public who may receive care by Respondent if he is permitted to continue the practice of medicine. Pursuant to the Findings of Fact

and Conclusions of Law set forth above, the Hearing Committee unanimously determined that Respondent's license should be suspended for a period of three years, but that the suspension be stayed provided that Respondent complies with significant terms of probation outlined below and that Respondent's license be permanently limited to prohibit him from practicing medicine as a hospitalist unless he has obtained the prior written approval of the Director of the Office of Professional Medical to work as part of multi-person group hospitalist practice with a defined shift structure.

During the three year probationary period, Respondent must only practice medicine in a setting with an onsite physician actively supervising him. Respondent is required to obtain the prior written approval by the Director of the Office of Professional Medical Conduct for any setting in which he practices medicine during the probationary period. The terms of the practice supervisor during the probationary period and the practice setting 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 First, Seventeenth, Twenty-third, Twenty-fourth, Twenty-fifth and Thirty-first 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's license to practice medicine in the State of New York is hereby **SUSPENDED FOR A PERIOD OF THREE YEARS WITH THE SUSPENSION STAYED**, provided the Respondent remains in compliance with the following terms of probation and license limitation;

4. Respondent is placed on **PROBATION FOR A PERIOD OF THREE YEARS** and must comply with the **TERMS OF PROBATION** annexed hereto as Attachment A;

5. Included in the terms of probation is a requirement that Respondent may practice medicine during the probationary period

only in a setting where he is under the **DIRECT ACTUAL SUPERVISION** of a licensed physician and for which he has obtained the prior written approval of the Director of the Office of Professional Medical Conduct.

6. Respondent's license to practice in New York is **PERMANENTLY LIMITED** to prohibit him from practicing as a hospitalist unless he has obtained the prior written approval of the Director of the Office of Professional Medical to work as part of multi-person group hospitalist practice with a defined shift structure; 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: Buffalo, New York
January 31, 2012

REDACTED SIGNATURE

STEVEN V. GRABIEC, M.D. (CHAIR)

SANFORD H. LEVY, M.D
HENRY M. SLOMA

TO: Timothy J. Mahar, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2512
Empire State Plaza
Albany, New York 12237

J. Mark Gruber, Esq.
Roach, Brown, McCarthy & Gruber, P.C.
1920 Liberty Building
Buffalo, New York 14202

Attachment A
Terms of Probation

1. Respondent shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

5. During the probationary period, Respondent shall be supervised in his medical practice by a licensed physician, proposed by Respondent and approved in writing by the Director of OPMC. The supervising physician must be in a position regularly to observe and assess Respondent's medical practice. Respondent shall ensure that the supervising physician submits quarterly reports to OPMC regarding the quality of Respondent's medical practice.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or

hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

APPENDIX I

Dept EXHIBIT
1
05/16/2011

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

IN THE MATTER

OF

TARIQ NIAZ AHMAD, M.D.

NOTICE
OF
HEARING

TO: Tariq Niaz Ahmad, M.D.
170 Rother Avenue
Buffalo, New York 14212

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 May 25, 2011, at 10:00 a.m., at the Hearing Room Part 6, Mahoney State Office Building, 65 Court Street, Buffalo, New York 14202, 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 11, 2011

REDACTED SIGNATURE

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

Inquiries should be directed to: Timothy J. Mahar
Associate Counsel
Bureau of Professional Medical Conduct
Room 2512, Corning Tower, ESP
Albany, New York 12237
(518) 473-4282

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

IN THE MATTER

OF

TARIQ NIAZ AHMAD, M.D.

STATEMENT

OF

CHARGES

Tariq Niaz Ahmad, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 29, 2002, by the issuance of license number 226999 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in Appendix A) in Mercy Hospital, Buffalo, New York from February 11, 2009 until his death, February 19, 2009 for bilateral effusions, among other conditions. Patient A had a mechanical mitral valve replacement in January 2009. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to order adequate anticoagulant therapy for Patient A and/or failed to appropriately review the order for anticoagulation therapy.
2. Respondent documented in Patient A's discharge summary that Patient A, who had died during the admission, did well and was discharged to home. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B in Mercy Hospital from April 10, 2007 until she died, April 29, 2007 for sepsis, among other conditions. Respondent's medical care of Patient B deviated from accepted

standards of care as follows:

1. Respondent failed to examine Patient B on one or more of the following days April 22, 2007, April 23, 2007 and April 24, 2007 and/or Respondent failed to document a progress note on those dates.
2. On or after April 25, 2007, Respondent entered a note in Patient B's medical record which he dated "April 23, 2007" when Respondent knew that he had not written the note in the medical record on April 23, 2007.
3. On or after April 25, 2007, Respondent entered a note in Patient B's medical record which he represented as having been written on April 24, 2007, when Respondent knew that he had not written the note in the medical record on April 24, 2007.
4. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C in Mercy Hospital from June 20, 2008 through June 23, 2008 for lower extremity edema, elevated creatinine and bilateral plural effusions, among other conditions. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient C on various occasions during the admission.
2. Respondent failed to adequately manage Patient C's anticoagulation therapy at various times during the hospital admission and/or at the time of discharge.
3. Respondent inappropriately discharged Patient C on Metformin.
4. Respondent failed during the hospitalization and/or at discharge failed

to continue Patient C on one or more medications which had been prescribed to Patient C prior to admission and/or failed to adequately document his rationale for not continuing the medications.

5. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided medical care to Patient D at Mercy Hospital from June 14, 2008 until her death, June 15, 2008 for chest pain and bilateral pulmonary embolism, among other conditions. Respondent's medical care of Patient D deviated from accepted standards of care as follows:

1. Respondent failed to timely and/or adequately respond to attempts by hospital staff to contact him between 3:01 AM and 4:25 AM on June 15, 2008 regarding Patient D's change in condition.
2. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent provided medical care to Patient E at the Absolut of Aurora Park, a nursing facility in Aurora Park, New York, during the period including September, 2008. During that period, Patient E fell and sustained a distal femoral fracture. Respondent's medical care deviated from accepted standards of care as follows:

1. Respondent failed to adequately and/or timely respond to a report from the nursing staff that radiology had recommended that additional x-rays be obtained of Patient E's leg.

~~2. Respondent on one or more occasions, failed to adequately and/or timely respond to a report from the nursing staff that Patient E's INR was elevated and/or failed to provide an appropriate and/or reliable~~

Withdrawn by Dept. No objection
JR 5/25/11

means for the nursing staff to communicate with Respondent regarding patient care issues.

3. Respondent failed to maintain an adequate medical record for Patient E .

F. Respondent provided medical care to Patient F at Mercy Hospital from April 1, 2006 through April 10, 2006 for acute coronary syndrome and new onset atrial fibrillation, among other conditions. Respondent's medical care of Patient F deviated from accepted standards of medical care as follows:

1. During Patient F's admission to Mercy Hospital from April 1, 2006 through April 10, 2006, Respondent failed to obtain a timely and/or adequate history regarding Patient F's allergy to Cardizem and/or failed to timely and/or adequately document that history.
2. Respondent failed to maintain an adequate medical record for Patient F.

G. Respondent provided medical care to Patient G in Mercy Hospital from June 6, 2007 through June 22, 2007, for myocardial infarction and complaints of chest pain post placement of cardiac stents, among other conditions. Respondent's medical care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to adequately and/or timely evaluate Patient G during the hospital care from June 10, 2007 through June 12, 2007.
2. Respondent failed to adequately and/or timely diagnose Patient G's condition during the hospital care from June 10, 2007 through June 12, 2007.
3. Respondent failed to timely admit Patient G to the hospital and/or

failed to adequately and/or timely treat Patient G's condition during the hospital care from June 10, 2007 through June 12, 2007.

4. Respondent failed to adequately and/or timely consult with the emergency department physician regarding Patient G's condition during the hospital care from June 10, 2007 through June 12, 2007.

5. Respondent failed to maintain an adequate medical record for Patient G during the hospital care from June 10, 2007 through June 12, 2007.

H. Respondent provided medical care to Patient H at Mercy Hospital during separate admissions on December 20, 2006 through December 22, 2006 and then during readmission on December 23, 2006 until Respondent's discharge from Patient H's care on December 24, 2006. Patient H had hypotension and respiratory distress, among other conditions. Respondent's medical care deviated from accepted standards of care as follows:

1. ~~Respondent failed to obtain an adequate medical history~~ and/or ~~failed to perform an adequate physical examination of Patient H during the readmission on December 23, 2006~~. Withdrawn 7/21/11 no objection KL.

2. Respondent failed to adequately respond to attempts to report Patient H's condition to Respondent following Patient H's readmission to Mercy Hospital on December 23, 2006.

3. Respondent failed to maintain an adequate medical record for Patient H.

I. Respondent provided medical care to Patient I in Mercy Hospital from April 3, 2007 until her death on April 8, 2007 for lower extremity cellulites, diabetes and anemia, among other conditions. Respondent's medical care of Patient I deviated from accepted standards of care as follows:

1. Respondent failed to adequately treat Patient I with antibiotics during the hospital admission.
2. Respondent failed to document an appropriate, adequate and/or timely death summary for Patient I.
3. Respondent failed to maintain an adequate medical record for Patient I.

SPECIFICATION OF CHARGES

SPECIFICATIONS ONE THROUGH EIGHT

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 following Factual Allegations:

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

SPECIFICATIONS NINE THROUGH SIXTEEN

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530 (6) by practicing the profession of medicine with gross incompetence on a particular occasion as alleged in the following Factual Allegations:

9. The facts as alleged in paragraphs A and A.1 and/or A and A.2.

10. The facts as alleged in paragraphs B and B.1 and/or B and B.2, and/or B and B.3.

11. The facts as alleged in paragraphs C and C.1 and/or C and C.2. and/or C and C.3..

12. The facts as alleged in paragraphs D and D.1.

13. The facts as alleged in paragraphs E and E.2.

14. The facts as alleged in paragraphs F and F.1.

15. The facts as alleged in paragraphs G and G.1, and/or G and G.2, and/or G and G.3, and/or G and G.4.

16. The facts as alleged in paragraphs H and H.1 and/or H and H.2.

SEVENTEENTH 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 on two or more of the following Factual Allegations:

17. The facts as alleged in paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, B and B.4, 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, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, I and I.3.

EIGHTEENTH 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 two or more of the following Factual Allegations:

18. The facts as alleged in paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, B and B.4, 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, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, H and H.1, H and H.2, H and H.3, I and I.1, I and I.2, and/or I and I.3.

NINETEENTH AND TWENTIETH SPECIFICATIONS

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charges with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently or beyond its authorized scope as alleged in the following Factual Allegations:

19. The facts as alleged in paragraphs B and B.2.

20. The facts as alleged in paragraphs B and B.3.

TWENTY-FIRST AND TWENTY-SECOND SPECIFICATIONS

MAKING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report as alleged in the following Factual Allegations:

21. The facts as alleged in paragraphs B and B.2.

22. The facts as alleged in paragraphs B and B.3.

TWENTY-THIRD THROUGH THIRTY-FIRST SPECIFICATIONS

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the following Factual Allegations:

23. The facts as alleged in paragraph A and A.2.
24. The facts as alleged in paragraph B and B.2, and/or B and B.3, and/or B and B.4.
25. The facts as alleged in paragraph C and C.5.
26. The facts as alleged in paragraph D and D.2.
27. The facts as alleged in paragraph E and E.3.
28. The facts as alleged in paragraphs F and F.3.
29. The facts as alleged in paragraph G and G.5.
30. The facts as alleged in paragraph H and H.3.
31. The facts as alleged in paragraph I and I.2 and/or I and I.3.

THIRTY-SECOND THROUGH THIRTY-THIRD SPECIFICATIONS

MORAL UNFITNESS

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

32. The facts as alleged in paragraph B and B.2.
33. The facts as alleged in paragraph B and B.3.

DATE: April 11, 2011
Albany, New York

REDACTED SIGNATURE

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