NEW YORK
state department of
HEALTH

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

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

Public

December 9, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kamyar Tavakoli, M.D.
191-15 Hillside Avenue
Hollis, New York 11423

Paul E. Walker, PLLC
315 West 106th Street – Suite 1A
New York, New York 10025

Courtney Berry, Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Kamyar Tavakoli, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-301) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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

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

Sincerely,

REDACTED
James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

KAMYAR TAVAKOLI, M.D.

COPY

DETERMINATION

AND

ORDER

BPMC #14-301

A Notice of Hearing and a Statement of Charges, both dated November 26, 2013, were personally served on the Respondent. (Exhibit 1) Trevor Litchmore M.D., Chair, Prospere Remy, M.D., and Jay Zimmerman, Ph.D., members of the State Board for Professional Medical Conduct ("BPMC"), served as the hearing committee in this matter pursuant to Section 230(10) of the Public Health Law ("PHL"). Denise Lepicier, Esq., Administrative Law Judge ("ALJ"), served as the hearing officer.

The Department of Health appeared by Courtney Berry, Esq., Associate Counsel, Bureau of Professional Medical Conduct. Respondent Kamyar Tavakoli, M.D., was represented by Paul E. Walker, Esq.

Evidence was received; witnesses were sworn and heard; and transcripts were made of these proceedings. After consideration of the entire record, the hearing committee issues this Determination and Order.

PROCEDURAL HISTORY

Answer Filed by Respondent:	January 10, 2014
Pre-Hearing Conference:	January 10, 2014

Hearing Dates	May 22, 2014
	July 16, 2014
	September 16, 2014
Witnesses for Petitioner:	Jeffrey Levine, M.D.
	Lawrence Matlin, Senior Medical Conduct Investigator
Witnesses for Respondent:	Douglas Prisco, M.D.
	Marc Singer, M.D.
	Syed Ali, M.D.
	Kamyar Tavakoli, M.D.
Deliberations Held:	October 16, 2014

BACKGROUND

The State Board for Professional Medical Conduct ("BPMC") is a professional disciplinary agency of the State of New York, authorized pursuant to PHL § 230, et seq., to consider certain disciplinary matters brought by the Department of Health. This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct. The Department of Health has jurisdiction to conduct disciplinary hearings for physicians, physician assistants, specialist assistants, physicians working on a limited permit, and medical residents when there is a violation of the misconduct provisions of the N.Y. Education Law ("Educ. Law").

The Respondent is charged with seven specifications of misconduct in the Statement of Charges. Specification one charges the Respondent with negligence on more than one occasion in the treatment of five patients in violation of Educ. Law § 6530(3). The second specification

charges the respondent with incompetence on more than one occasion with respect to the same five patients in violation of Educ. Law § 6530(5). The third through seventh specifications charge that the Respondent failed to maintain a record that accurately reflected the evaluation and treatment of the five patients in violation of Educ. Law § 6530(32).

Respondent filed an answer to the Statement of Charges denying all the factual allegations and each of the specifications of charges. (Ex. A) A copy of the Statement of Charges is attached to this Determination and Order as Appendix 1. A copy of the Respondent's Answer is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers and letters in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the hearing committee in arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited evidence.

General Findings

1. The Respondent was licensed to practice medicine as a physician in the State of New York on October 8, 1992, upon issuance of license number 190615 by the New York State Education Department. (Ex. 2)

2. Respondent certified a set of medical records as "complete, true and exact" copies of the medical records for Patients A through E on November 11, 2011. (Ex. 3, 4, 5, 6 and7). At an interview on June 2, 2012, at Office of Professional Medical Conduct offices, Respondent submitted pages to add to these medical records. (Ex. 9, 3A, 4A, 5A, 6A and 7A; T. 342-343)

At hearing, Respondent introduced, for purposes of mitigation, much larger sets of medical records for these patients that allegedly demonstrate how Respondent's record keeping has improved. (Ex. B, C, D, E & F) However, it is not possible to credit Respondent's recent records because some past medical notes now appear to include additional information and some visits have been added. (cf. Ex. 7 & Ex. F, see office visits for 3/2/01, 5/31/01, 7/17/01, 9/20/01, 1/8/02, 2/18/02, 3/2/02, 7/16/02, 9/12/02, 9/28/02, 6/10/03, 9/18/03, 10/30/03, 9/28/04, 10/26/04, 12/7/04, 6/4/07, 7/10/07, 9/10/07, 10/15/07) Further, there are documents in Respondent's exhibits, including laboratory tests, for which there are no corresponding office visits noted in the medical records. (T. 670-673)

3. The purpose of a medical record is to document observations and decision making regarding the care of a patient. (T. 21) A medical record is to provide anyone who needs to review the past medical history of a patient, including the recording physician, a record of past medical care. (T. 36-37) It is a record of what has happened to the patient medically. (T. 250)

4. A minimally acceptable medical record for an internist should document a past family and personal medical history, a chief complaint, a history of the complaint, a review of systems, a physical exam including blood pressure, pulse, respiration, temperature, and relevant positive and negative physical findings. It should include an assessment of problems, including in the case of pain whether it was episodic and what made it better or worse, and the plan, including whatever diagnostic tests are ordered and any medications prescribed or changed. (T. 21-22, 95-97, 109-121, 305-308) The medical record should also reflect whether and how prior medical issues have been resolved. (T. 25-26)

5. If a patient is seen at an office visit, the visit should be recorded in the patient's medical record. (T. 434) If a physician does a physical examination, it should be recorded in the medical

record. (T. 36) If a physician writes a prescription for a patient it should be noted in the medical record. (T. 158-160)

6. Respondent admitted with respect to the medical records of each of the patients involved in this matter that his records were illegible and that he should have documented more. (Ex. 9)

7. Because of the potential for abuse, non-steroidal anti-inflammatories should be tried for pain relief before starting opiates and/or benzodiazepines. A physician should provide justification in his record for prescribing controlled substances and should document the specific chief complaint of the pain, the initiation, duration, quality and radiation of the pain, any prior treatment and what makes the pain better or worse. It is important to document what other medications the patient is taking to insure that there are no contraindications for taking the medications at the same time. For example, prescribing both opioids and benzodiazepines can be a concern as these medications are both sedating and addicting. (T. 33, 113-115) It is also important for a physician to physically examine the site of the pain and to record his findings. (T. 33-39, 43-45, 46-49, 105- 108, 111-115, 178-181, 252, 271-273, 303-304, 384-387) When a patient evidences signs of abuse of controlled substances, drugs with the potential for abuse should not be prescribed. (T. 221-223)

Patient A

8. Respondent treated Patient A between January of 2001 and October of 2011, the time period considered at this hearing. (Ex. 3, 3A & 3B)

9. On May 23, 2003, Patient A complained of heart palpitations. Respondent failed to record findings of a physical exam other than to record "p.e. unchanged" when the last physical exam in the record was two years prior. (Ex. 3, p. 3; T. 28)

10. Patient A had his gallbladder removed in April of 2003. Respondent's notes fail to address any physical findings or assessment of gallbladder issues despite the fact that the patient's initial complaint was gastric in nature. (T. 31-32; Ex. 3, pp. 49-51)

11. On December 2, 2004, Respondent noted that Patient A fell on ice. Respondent failed to examine or document Patient A's range of motion or tenderness. (Ex. 3, p. 6; Ex. 9; T. 34-35, 384-387)

12. On February 7, 2005, Respondent noted that Patient A crashed into a tree while skiing. Respondent recorded no physical exam. (Ex. 3, p. 6; T. 35-36)

13. Respondent failed to perform or document physical examinations and physical findings regarding Patient A's pain on the following visits (T. 24-49, 97-101; Ex. 3, 3A & 3B): January 29, 2001; February 11, 2003; February 24, 2003; May 23, 2003; November 4, 2003; October, 2, 2004; February 16, 2006; May 2, 2006; August 17, 2006; September 6, 2006; September 16, 2006; September 30, 2006; July 10, 2007; August 21, 2008; and September 25, 2008.

14. Respondent prescribed Percocet, Benzodiazepines and Ambien to Patient A inappropriately on the following visits (T. 33-34, 97-101; Ex. 3, 3A & 3B): May 23, 2003; November 4, 2003; October 2, 2004; February 16, 2006; May 2, 2006; August 17, 2006; September 6, 2006; September 16, 2006; September 30, 2006; July 10, 2007; August 20, 2008; and September 25, 2008.

15. Respondent failed to maintain an adequate, legible medical record for Patient A from January of 2001 to October of 2011. (T. 18-49; Ex. 3, 3A & 3B)

The hearing committee unanimously sustained the factual allegations in paragraphs A, A1, A2 and A4. The hearing committee did not sustain factual allegation A3.

Patient B

16. Respondent treated Patient B between May of 1996 and June of 2011. (Ex. 4 & 4A)

17. At the office visit on February 17, 1997, Respondent wrote: "still pain – right wrist." Respondent diagnosed tendonitis, but no physical exam or findings were documented. (Ex. 4, p.2)

18. At his interview with the Office of Professional Medical Conduct, Respondent stated that at the June 30, 2009, office visit with Patient B, he diagnosed rheumatoid arthritis. (Ex. 9) The office note for June 30, 2009, does not include a physical examination or mention rheumatoid arthritis. (Ex. 4, p. 9; T. 352-353)

19. Although Respondent noted in Patient B's medical record on February 16, 2012, that Patient B had asthma, at hearing he testified that she did not have asthma. (Ex. 4A; T. 602-605) At this same visit Respondent recorded Ventolin, Ultram and Tylenol 500 as current medications. At hearing he testified that this information was not correct. (Ex. 4A; T. 602-605)

20. Respondent failed to perform and/or document physical examinations and findings with regard to Patient B's pain, rheumatoid arthritis, asthma, lupus and/or autoimmune disease on the following visits (T. 141-161; Ex. 4 & 4A): February 9, 1997; February 17, 1997; April 19, 1997; May 3, 1997; May 8, 1997; August 9, 1997; January 10, 1997[8]; March 2, 1998; March 9, 1998; May 30, 1998; November 19, 1998; May 1, 1999; November 13, 1999; December 2, 1999; January 27, 2000; and March 23, 2000.

21. Respondent admitted at interview that he would mail prescriptions for pain medication to Patient B that she would fill in Pennsylvania. (Ex. 9; T. 353-354) At a minimum, Respondent prescribed pain medications to Patient B without examining the patient or documenting the prescriptions on September 25, 2007 and March 10, 2009. (T. 179-181; Ex 4 & 4A)

22. Respondent failed to maintain an adequate, legible medical record for Patient B. (T. 141-161; 179-190; Ex. 4 & 4A)

The hearing committee unanimously sustained the factual allegations in paragraphs B, B1, B3 and B4. The hearing committee did not sustain factual allegation B2.

Patient C

23. Respondent treated Patient C between March of 1999 and August of 2006. (Ex. 5 & 5A)

24. Respondent has a patient information sheet for Patient C dated November 5, 1998. (Ex. 5, p. 48) In a letter Respondent wrote dated April 18, 2005, Respondent confirmed that Patient C had been under his care since November 5, 1998. (Ex. D) Yet, Respondent has no entries in Patient C's medical record prior to March 11, 1999. (Ex. 5; T. 693-694)

25. At the March 11, 1999, office visit, Respondent recorded no history or physical exam, but prescribed Percocet. (Ex. 5, p.2; T. 197-198)

26. At the June 8, 1999, office visit, Respondent recorded a weight and blood pressure, but no physical exam, and prescribed Donnatal, a medication for irritable bowel syndrome. (Ex. 5, p.2; T. 199) Respondent should have performed and recorded a physical examination of the abdomen. (T. 199)

27. The July 6, 1999, office visit only has a weight recorded. This is an inadequate office visit note. (T. 199-200)

28. At the November 1, 1999, office visit, Respondent recorded that Patient C reported that he "Lost Percocet!" Respondent recorded nothing about the patient's loss of this controlled substance, and then Respondent prescribed Vicodin. Respondent did not record why he changed the medication or his justification for the change. (Ex. 5, p. 9; T. 200-205, 465-466, 695-696)

Respondent admitted at hearing that this loss was a possible sign of drug abuse. (T. 711)

29. At the April 12, 2003, office visit, Patient C reported that Percocet makes him nauseous. Respondent prescribed Oxycontin and Ativan. On June 19, 2003, Respondent switched Respondent's medications to Percocet and Xanax without recording the indications for this change or his reasoning. (Ex. 5, p. 17; T. 218-220; 696-697)

30. Respondent mentioned pain management and psychiatry in a number of his notes, but never recorded whether or not Patient C saw these specialists. (Ex. 5, p. 15-17; T. 697-701)

31. At the November 4, 2003, office visit, Respondent recorded "Had pneumonia? Tense and anxious, Ativan." No physical exam was recorded. Respondent apparently did not even listen to Patient C's lungs. (Ex. 5, p. 18; T. 468)

32. At the December 23, 2003, office visit, the patient complained of left foot pain, but no examination of the foot was recorded, although pain medication was prescribed. (Ex. 5, p. 18; T. 468-469)

33. At the January 29, 2004, office visit, the Respondent noted "cellulitis of the left forearm, secondary to needle." There is no indication of inquiry concerning the possibility of drug abuse by Patient C and Respondent should have followed up on this issue. (Ex. 5, p. 18; T. 221-223, 469-470) Instead, Respondent continued to prescribe Percocet and Vicodin to Patient C in violation of the standard of care. (Ex. 5, p. 18; T. 223, 267-269) Respondent testified at hearing that this physical finding did not make him suspicious and that he did not consider withholding opioids from this patient. (T. 702-703, 710-712)

34. Respondent continued to prescribe Percocet, Vicodin or Fentanyl patches for Patient C without conducting physical examinations or indicating his reasoning on February 26, 2004; December 2, 2004; June 20, 2005; June 25, 2005; June 28, 2005; July 14, 2005; December 29,

2005; January 26, 2006; and August 10, 2006. (Ex. 5, p. 3-5; T. 224-226, 703-704)

35. Respondent failed to perform or document physical examinations and findings regarding Patient C's arthritis and back pain on the following visits (T. 197-233; Ex. 5 & 5A): March 11, 1999; November 1, 1999; April 12, 2003; June 19, 2003; August 14, 2003; December 23, 2003; January 29, 2004; February 26, 2004; June 20, 2005; July 14, 2005; October 20, 2005; December 29, 2005; January 26, 2006; August 10, 2006; February 18, 2006; March 13, 2006, April 10, 2006; and May 4, 2006.

36. Respondent inappropriately prescribed Percocet, Vicodin and/or Fentanyl patches for Patient C on the following dates (T. 197-233, 272-; Ex. 5 & 5A): March 11, 1999; November 1, 1999; April 12, 2003; June 19, 2003; August 14, 2003; January 29, 2004; February 26, 2004; June 20, 2005; July 14, 2005; December 29, 2005; January 26, 2006; August 10, 2006; and February 18, 2006. Indeed, Respondent missed signs of drug abuse in this patient. (T. 266-269)

37. Respondent failed to perform appropriate follow-up, including referrals to physical therapy, an orthopedist, or a pain management specialist. (T. 265-271, 273-275)

38. Respondent failed to maintain an adequate, legible medical record for Patient C. (T. 197-233, 242-244, 247, 249-250, 258-259, 261, 265; Ex. 5 & 5A)

The hearing committee unanimously sustained the factual allegations in paragraphs C, C1, C2, C3 and C4.

Patient D

39. Respondent treated Patient D between 1993 and 2011. (Ex. 6 & 6A)

40. Respondent admitted at an interview that he could not explain the absence of records for Patient D from 1993 to 2001. (Ex. 9, p. 5) The loss of a patient's medical records is not

acceptable. (T. 277)

41. Patient D had a very abnormal Magnetic Resonance Image (MRI) of her brain on December 26, 2006. (Ex. 6, p. 59; T. 277-278) The report of this MRI is dated January 4, 2007. (Ex. 6, p. 59)

42. On January 29, 2007, Respondent recorded in his medical record for Patient D that the MRI was "normal." (Ex 6, p.33; Ex. E, 1/29/07 note)

43. Respondent did not refer Patient D to another specialist with respect to these abnormal findings until two years later. This was too long a period of time to pass before making this referral. There is also no further mention of this referral or of its results in the record. (T. 289-291, 299-301)

44. Patient D had blood testing reported on February 10, 2010, that evidenced a microcytic anemia. (T. 282-283; Ex. 6, p. 89)

45. Respondent failed to do or note any follow-up on this anemia, which could indicate some sort of blood loss or dietary deficiency. (T.282-283, 293-294)

46. Respondent failed to maintain an adequate, legible medical record for Patient D. (T. 277-283; Ex. 6 & 6A; Ex. 9, p.5)

The hearing committee unanimously sustained the factual allegations in paragraphs D and D2. The hearing committee sustained factual allegation D1 by a vote of two to one.

Patient E

47. Respondent treated Patient E for purposes of this hearing between December of 2000 and August of 2011. (Ex. 7 & 7A)

48. Respondent prescribed opiates and benzodiazepines to Patient E without documented

indication on the following visits (T. 303-308; Ex. 7 & 7A): December 12, 2000; September 18, 2003; August 8, 2005; December 22, 2005; August 29, 2006; September 6, 2006; January 9, 2007; October 15, 2007; November 17, 2007; December 20, 2007; March 6, 2008, July 15, 2008; December 13, 2008; July 21, 2009; April 15, 2010; and August 18, 2010.

49. Dilantin is a medication for seizures that must be taken daily and followed to insure therapeutic drug levels. (T. 309-310) Respondent prescribed Dilantin intermittently when the patient reported that he had seizures and failed to follow-up on a sub-therapeutic Dilantin level. (T. 309-318, 325-328, 720; Ex. 7, p. 50) Respondent testified at hearing that he now does not believe the patient had seizures and that he did not do Dilantin levels more frequently because the patient was not compliant with his medication. (720-739)

50. Respondent failed to maintain an adequate, legible medical record for Patient E. (T. 303-328; Ex. 7 & 7A)

The hearing committee unanimously sustained the factual allegations in paragraphs E, E1 and E3. The hearing committee unanimously sustained the factual allegation in paragraph E2 with respect to the patient's Dilantin level.

DISCUSSION

The hearing committee has sustained all but two of the factual allegations. In doing so it considered all the evidence presented by each of the parties and credited the evidence it found persuasive. The committee did not sustain allegations A3 and B2 because it did not feel it had adequate information to determine the standard for follow-up or referral in those two instances. However, the committee was unanimously convinced that the Respondent's medical records were egregiously deficient and that, despite the paucity of evidence in the medical records, there

was proof that there was inadequate patient care.

At the outset, the committee notes that it found the Department's expert, Jeffrey Levine, M.D., to be credible, and found that Respondent's three professional witnesses did not add much to the committee's understanding of the case. Douglas Prisco, M.D., testified that he would rather testify to Respondent's character than comment on the records which he could not defend. (T. 415-416, 435-436, 455, 468, 477-480) Marc Singer, M.D., admitted that it is not medically acceptable for a large portion of Patient D's chart to be missing. (T. 495-496) Further, the committee found that the testimony of Syed Ali, M.D., could not be credited because he testified that a different standard of care applied to the "well educated" patient population in the area where Dr. Tavakoli practiced. (T. 550-555)

While Respondent's records are largely illegible, it is clear that in many instances Respondent conducted or recorded no physical examinations and usually recorded nothing in terms of plan or reasoning. Respondent argued at hearing that his switch to electronic medical records will solve the problems with his records because he will be required to fill in the various fields. It is true that typed records will solve the legibility problems. However, electronic medical records will not cure bad medicine.

This case largely involved the inappropriate prescription of controlled substances. Respondent testified that he will no longer prescribe controlled substances, but a physician may need to provide pain medication in an appropriate circumstance. Respondent must know how to prescribe appropriately. This hearing demonstrated that Respondent repeatedly missed or ignored signs of drug abuse in his patients. Patient A apparently tried to alter a prescription Respondent wrote for him in November of 2006. (T. 42, 103-104, 684-686) Nevertheless, Respondent continued to prescribe controlled substances for Patient A. He also missed signs of

drug abuse in Patient C who at one visit reported he had lost his controlled substance medication and on another visit had an infection in his arm as the result of a needle.

Other medical issues were also ignored. At his interview with the Office of Professional Medical Conduct, Respondent stated that on June 30, 2009, he determined that Patient B had rheumatoid arthritis, but the note for that date evidences no physical exam and does not mention rheumatoid arthritis, much less describe a plan for testing or treatment. Patient C complained of nausea from Percocet and, yet, after a brief period with another opioid, Respondent re-prescribed Percocet without explanation. Patient D had an abnormal Magnetic Resonance Image of her brain, yet Respondent characterized it as "normal." Patient E reported having seizures, a medical problem requiring consistent care. Respondent did no testing but prescribed Dilantin intermittently and at hearing stated he now does not believe the patient was having seizures. Finally, there are medical records for Patient E that do not appear in his original written records and some of the typed transcriptions of the handwritten records contain new information in visits that are over ten years old. It is difficult to understand what Respondent was or is thinking about his patients at any particular time.

Where there is a relationship between inadequate recordkeeping and patient treatment, the failure to keep adequate and accurate records may be considered negligence. Youssef v. State Board for Professional Medical Conduct, 6 AD3d 824, 775 NYS2d 395 (3rd Dept. 2004); Matter of Bogdan v. New York State Board for Professional Medical Conduct, 195 AD2d 85, 606 NYS2d 381 (3rd Dept. 1993), *appeal dismissed and lv. denied* 83 NY2d 901, 614 NYS2d 381 (NY 1994). This is such a case. Respondent's wholly inadequate records and his failure to deal with medical issues require this committee to conclude Respondent was negligent. Moreover, his inadequate assessment of medical issues compels a conclusion that he was also incompetent.

Finally, Respondent himself admitted that his records were wholly inadequate, and the committee concurs. (T. 615-622)

SPECIFICATIONS OF MISCONDUCT

All the following determinations with respect to the specifications were unanimous. The committee relied on a memorandum of law by former counsel for the Department of Health relating to various definitions of misconduct, where appropriate, to make its determinations. The parties were invited to challenge the definitions at the beginning of the hearing, but neither of the parties did so.

The first specification charges negligence on more than one occasion in violation of Education Law § 6530(3) and relies on the sustained factual allegations with respect to the five patients who were the subject of this case. Respondent routinely failed to perform physical examinations on the five patients to whom he prescribed a multitude of controlled substances. Indeed, when a patient reported an injury as the cause of his/her pain, Respondent did not even examine the locus of the injury. Respondent prescribed multiple opioids and benzodiazepines, often simultaneously, and failed to document or justify the reasons for the prescriptions. Where a patient evidenced signs of drug abuse, Respondent ignored the signs. Where a patient complained of seizures, Respondent failed to treat the patient appropriately and prescribed controlled substances. The Department has demonstrated with respect to each of the factual allegations sustained that the Respondent did not meet the standard of care that is required of a reasonably prudent physician under the circumstances. **The FIRST SPECIFICATION of misconduct is SUSTAINED.**

The second specification charges incompetence on more than one occasion in violation of Education Law § 6530(5) and relies on all the factual allegations with respect to the five patients

who were the subject of this case. The Department has demonstrated with respect to each of the sustained factual allegations that the Respondent lacks the requisite skill or knowledge to practice medicine competently. Respondent himself testified that he did not understand the risks of prescribing different classes of controlled substances in combination until he took a recent course. The committee does not find it entirely credible that Respondent was unaware of the risks of this pattern of prescribing, but does believe that Respondent's practice evidences incompetence. His medical records demonstrate a lack of understanding of the very process of medical practice. Medical issues arise in his records, may or may not be treated, and are dropped from mention without any sort of resolution. His practice appears as haphazard and disorganized as his records. **The SECOND SPECIFICATION of misconduct is SUSTAINED.**

The third through seventh specifications of misconduct charge a failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in violation of Education Law § 6530(32). The third through sixth specifications are sustained based on the following paragraphs A and A4; B and B4; C and C4; and D and D2 in the factual allegations. The committee sustains these charges because Respondent did not record necessary and pertinent information for each of these patients, sometimes even recording nothing for an office visit. The seventh specification of misconduct is not sustained due to an apparent clerical problem with the numbering of the paragraphs. **The THIRD THROUGH SIXTH SPECIFICATIONS of misconduct are SUSTAINED. The SEVENTH SPECIFICATION is NOT SUSTAINED.**

DETERMINATION AS TO SANCTION

The Hearing Committee has considered the full range of sanctions available pursuant to PHL § 230-a, including: (1) censure and reprimand; (2) suspension of the license, wholly or partially; (3) limitation on practice; (4) revocation of the license; (5) annulment of the license or registration; (6) limitation on registration or further licensure; (7) monetary penalties; (8) a course of education or training; (9) performance of public service; and, (10) probation. The Committee has concluded that the appropriate sanction is a two year suspension of the Respondent's license, stayed, with probation (Appendix 3) during the period of the stayed suspension.

ORDER

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

1. The **FIRST** through **SIXTH SPECIFICATIONS** contained in the Statement of Charges are **SUSTAINED**; and

2. The **SEVENTH SPECIFICATION** in the Statement of Charges is **NOT SUSTAINED**; and

3. Respondent is sanctioned with a **two (2) year SUSPENSION**, which is **STAYED**, and he is placed on **PROBATION for a period of two (2) years** and must complete **fifty (50) hours of Continuing Medical Education during the period of probation** and must **refrain from prescribing controlled substances during the period of probation**, as specified in the attached Terms of Probation;

4. This Order shall be effective on personal service on the Respondent, or seven (7) days after the date of mailing of a copy to Respondent's last known address by certified mail.

DATED: New York
December 6th, 2014

REDACTED

TREVOR LITCHMORE, M.D., Chair

PROSPERE REMY, M.D.
JAY ZIMMERMAN, Ph.D.

TO:

Kamyar Tavakoli, M.D.
191-15 Hillside Avenue
Hollis, N.Y. 11423

Paul E. Walker, PLLC
315 West 106th Street, Suite 1A
New York, New York 10025

Courtney Berry, Associate Counsel
New York State Department of Health
Division of Legal Affairs
Bureau of Professional Medical Conduct
90 Church Street, 4th floor
New York, N.Y. 10007

APPENDIX 1

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

IN THE MATTER OF **Kamyar D. Tavakoli, M.D.**	STATEMENT OF CHARGES

Kamyar D. Tavakoli, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 8, 1992, by the issuance of license number 190615 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, an internal medicine physician, treated Patient A at his office in Hollis, N.Y. from in or about January 2001 through in or about October 2011. Respondent deviated from accepted medical standards in that:

1. Respondent failed to perform and/or document physical examinations and findings regarding Patient A's pain.

2. Respondent inappropriately prescribed Percocet and Ambien to Patient A. Benzodiazepines, 1/10/14 Amended DL

3. Respondent failed to perform appropriate follow-up, including referrals to physical therapy and/or a pain management specialist.

4. Respondent failed to maintain an adequate, legible record for Patient A.

B. Respondent treated Patient B at his office in Hollis, N.Y. from in or about May 1996 through in or about June 2010. Respondent continued to prescribe for Patient B until 2012. Respondent deviated from accepted medical standards in that:

1. Respondent failed to perform and/or document physical examinations and findings with regard to Patient B's pain, Rheumatoid arthritis, asthma, lupus and /or autoimmune deficiency.

2. Respondent failed to perform appropriate follow-up for Patient B's conditions, including referrals to an obstetrician or any other specialist.

3. Respondent prescribed pain medications to Patient B, without examining the patient or documenting the prescription.

4. Respondent failed to maintain an adequate, legible record for Patient B.

C. Respondent treated Patient C at his office in Hollis, N.Y. from in or about March 1999 through in or about August 2006. Respondent deviated from accepted medical standards in that:

1. Respondent failed to perform and/or document physical examinations and findings regarding Patient C's arthritis and back pain.

2. Respondent inappropriately prescribed Percocet, Vicodin and/or Fentanyl patches for Patient C.

3. Respondent failed to perform appropriate follow-up, including referrals to physical therapy, an orthopedist or a pain management specialist.

4. Respondent failed to maintain an adequate, legible record for Patient C.

D. Respondent treated Patient D at his office in Hollis, N.Y. in or about 1993 through in or about 2011. Respondent deviated from accepted medical standards in that:

1. Respondent failed to perform appropriate follow-up of abnormal test results.

2. Respondent failed to maintain an adequate, complete, and/or legible record for Patient D.

E. Respondent treated Patient E at his office in Hollis, N.Y. from in or about December 2000 through in or about August 2011. Respondent deviated from accepted medical standards in that:

1. Respondent prescribed opiates and benzodiazepines to Patient E without documented indications.

2. Respondent failed to follow up on abnormal test results, such as a sub-therapeutic Dilantin level, hypercholesterolemia and hypertriglyceridemia.

3. Respondent failed to maintain an adequate and/or legible record for Patient E.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A through E and their respective subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A through E and their respective subparagraphs.

THIRD THROUGH SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

3. Paragraph A, A2 and A4.
4. Paragraph B, B2 and B4.
5. Paragraph C, C2 and C4.
6. Paragraph D, and D2.
7. Paragraph E, E2 and E4.

DATE: November 26, 2013
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

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

IN THE MATTER OF

Answer to the Statement of Charges

KAMYAR D. TAVAKOLI, M.D.

KAMYAR D. TAVAKOLI, M.D., through his attorney, PAUL E. WALKER, PLLC, responds to OPMC's Statement of Charges, as follows:

1. Denies each and every statement in paragraphs "1" through "4" regarding patient "A".

2. Denies each and every statement in paragraphs "1" through "4" regarding patient "B".

3. Denies each and every statement in paragraphs "1" through "4" regarding patient "C".

4. Denies each and every statement in paragraphs "1" and "2" regarding patient "D".

5. Denies each and every statement in paragraphs "1", "2" and "3" regarding patient "E".

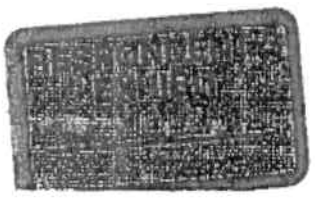
6. Denies each and every statement in paragraphs "1", "2", "3", "4", "5", "6" and "7" of the specifications regarding negligence, incompetence and failure to maintain records.

Dated: New York, New York
December 12, 2013

Yours, etc.,

REDACTED

PAUL E. WALKER, PLLC
315 West 106th Street, Suite 1A
New York, New York 10024



APPENDIX 3

TERMS OF PROBATION

1. Respondent's conduct shall conform to the moral and professional standards of conduct in his profession and in governing law. Any act of professional misconduct by Respondent as defined by New York Education Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York Public Health Law § 230 (10) or (19), or both.
2. Respondent shall remain in continuous compliance with all requirements of New York Education Law § 6502, including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in New York Education Law § 6502(4) to avoid registration and payment of fees.
3. Respondent shall provide to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, Suite 355, 150 Broadway, Albany, New York, 12204, at least every six months and as otherwise requested, or within thirty days of any change in the information, the following information in writing:
    a. a full description of the Respondent's employment and practice;
    b. all professional and residential addresses and telephone numbers within and outside of New York State;
    c. any and all information concerning investigations, arrests, charges, convictions or disciplinary actions by any local, state, or federal agency;
    d. any and all information concerning investigations, terminations, or disciplinary matters by any institution or facility.
4. Respondent shall provide to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, Suite 355, 150 Broadway, Albany, New York, 12204, copies of all applications relating to the practice of medicine, including but not limited to, privileges, insurance, and licensure, in any jurisdiction, concurrent with their submission.
5. Respondent shall cooperate fully with, and will respond within two weeks to, OPMC requests to provide written periodic verification of Respondent's compliance with these

terms of probation. Upon the Director of OPMC's request, Respondent shall meet personally with a person designated by the Director.

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty-day period. Respondent shall then notify the Director again at least fourteen days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume, and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose.
7. The Director of OPMC, or his/her designee, may review Respondent's professional performance. This review may include but shall not be limited to:
    a. A review of office records, patient records, hospital charts, and/or electronic records;
    b. Interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.
8. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients, and contain all information required by State rules and regulations concerning controlled substances.
9. Respondent shall not prescribe controlled substances while he is on probation.
10. Respondent shall enroll in and successfully complete twenty-five hours of Continuing Medical Education in the area of prescribing of controlled substances. Respondent shall enroll in and successfully complete twenty-five hours of Continuing Medical Education in the proper performance of and medical documentation of patient histories and physicals. All such courses are subject to the prior written approval of the Director of the Office of Professional Medical Conduct and courses taken in the past may not be used to fulfill this requirement.
11. Respondent shall comply with these Terms of Probation, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with or a violation of these terms, the Director of OPMC and/or the Board for Professional Medical Conduct

may initiate a violation of probation proceeding, and/or any other proceeding authorized by law, against the Respondent.