



# STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
*Commissioner*

Dennis P. Whalen  
*Executive Deputy Commissioner*

PUBLIC

March 28, 2005

## CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lloyd Ramraj Sookhu, M.D.  
164 Weeks Drive  
Dix Hills, New York 11746

Podlofsky, Orange & Kolenovsky  
Ira Podlofsky, Esq.  
98 Cutter Mill Road, #299-N  
Great Neck, New York 11021

Christine M. Radman, Esq.  
Assistant Counsel  
NYS Department of Health  
Office of Professional Medical Conduct  
Metropolitan Regional Office  
90 Church Street  
New York, New York 10007

**RE: In the Matter of Lloyd Ramraj Sookhu, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 05-52) 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

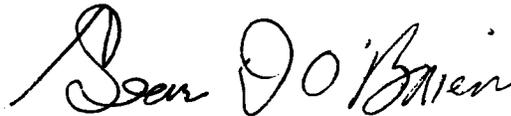
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge  
New York State Department of Health  
Bureau of Adjudication  
Hedley Park Place  
433 River Street, Fifth Floor  
Troy, New York 12180

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

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

Sincerely,

A handwritten signature in black ink that reads "Sean D. O'Brien". The signature is written in a cursive, flowing style.

Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:djh

Enclosure

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

**COPY**

**DETERMINATION**

**AND**

**ORDER**

**BPMC 05 - 52**

**IN THE MATTER**

**OF**

**LLOYD RAMRAJ SOOKHU, M.D.**

David Harris, M.D., M.P.H. (Chairperson), Robert Schiller, M.D., and Ms. Carmela Torrelli, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law. Marc P. Zylberberg, Esq., Administrative Law Judge, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by Christine M. Radman, Esq., Assistant Counsel. Respondent, Lloyd Ramraj Sookhu, M.D., appeared personally and was represented by Podlofsky, Orange & Kolenovsky by Ira Podlofsky, Esq. of Counsel

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

**PROCEDURAL HISTORY**

Date of Notice of Hearing and Statement of Charges:	September 27, 2004
Date of Answer to Charges:	October 5, 2004
Pre-Hearing Conferences Held:	October 19, 2004 November 9, 2004

Hearings Held: - (First Hearing day):

November 9, 2004  
January 4, 2005

Intra-Hearing Conference Held:

November 9, 2004  
January 4, 2005

Location of Hearings:

Offices of New York State  
Department of Health  
5 Penn Plaza, 6<sup>th</sup> Floor  
New York, NY 10001

Witnesses called (in the order they testified) by  
the Petitioner, Department of Health:

Karen Kirschner  
Arthur Gualtieri, M.D.  
Zaw Naing, M.D.  
Shirishbhai Patel, M.D.

Witnesses called (in the order they testified) by  
the Respondent, Lloyd Ramraj Sookhu, M.D.

Lloyd Ramraj Sookhu, M.D.

Department's Summation, Recommended Sanction,  
Findings of Fact, Conclusions of Law:

Received January 31, 2005

Respondent's Proposed Findings of Fact/  
Conclusions of Law:

Received February 1, 2005

Deliberations Held: (last day of Hearing)

February 22, 2005

### STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York ["P.H.L."]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Petitioner" or "Department") pursuant to §230 of the P.H.L. Lloyd Ramraj Sookhu, M.D. ("Respondent") is charged with three (3) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York ("Education Law").

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine fraudulently<sup>1</sup>; (2) failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient<sup>2</sup>; and (3) willfully making or filing a false report<sup>3</sup>.

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct towards one patient (Patient A<sup>4</sup>) in June 2002. Respondent admits to treating Patient A but denies all the other allegations and the Specifications of misconduct contained in the Statement of Charges. A copy of the Statement of Charges and the Answer is attached to this Determination and Order as Appendix 1 and Appendix 2.

### **FINDINGS OF FACT**

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

---

<sup>1</sup> Education Law §6530(2) - (the First Specification of the Statement of Charges [Department's Exhibit # 1]).

<sup>2</sup> Education Law §6530(32) - (the Second Specification of the Statement of Charges [Department's Exhibit # 1]).

<sup>3</sup> Education Law §6530(21) - (the Third Specification of the Statement of Charges [Department's Exhibit # 1]).

<sup>4</sup> The record and this Determination and Order refers to the patient by letter to protect patient privacy. Patient A is identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1).

1. Respondent was licensed to practice medicine in New York State on July 2, 1990 by the issuance of license number 182495 by the New York State Education Department (Department's Exhibit # 2)<sup>5</sup>.

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d] & §230[7] & §230[10]); (Department's Exhibit # 1); [P.H.T-11]<sup>6</sup>.

3. On June 4, 2002 Respondent was a House Physician at Mount Sinai Hospital in Queens, New York ("Mount Sinai Hospital"). Respondent held this position since 1993. Respondent's duties included covering the Emergency Room [T-320-321].

4. On June 4, 2002 Patient A came to the Emergency Room ("ER") of Mount Sinai Hospital as directed by his primary care physician, Dr. Steven Sowinski (now deceased), for leg swelling and pain, accompanied by fever (Department's Exhibit # 3).

5. The ER intake form described Patient A as a morbidly obese forty-five year old male who was alert and oriented. Patient A was triaged, and then medically evaluated by the ER physician on duty, Dr. Laura Michaeli (Department's Exhibit # 3, p.6).

6. On June 4, 2002 Patient A was admitted to the hospital with an admitting diagnosis of lower leg cellulitis. Respondent, as assigned House Physician on duty that evening, became responsible for taking and documenting Patient A's clinical history, and performing and documenting Patient A's physical examination (Department's Exhibit # 3, pp.11-14); [T-320-321].

---

<sup>5</sup> Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Lloyd Ramraj Sookhu (Respondent's Exhibit #).

<sup>6</sup> Numbers in brackets refer to Hearing transcript page numbers [T- ] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

7. Respondent documented findings in Patient A's medical records as though he had taken a clinical history and performed a physical examination (Department's Exhibit # 3, pp.11-14).

8. The clinical history and physical examination forms documenting Patient A's condition at 11:00 P.M. on June 2, 2002, were signed by Respondent and were written by Respondent. The notations contain no descriptive terms as to what was observed, felt, or heard by Respondent in the alleged physical exam performed by Respondent. Respondent's notations are comprised solely of conclusions and diagnoses identical to those found in the ER records (Department's Exhibit # 3, pp.6, 11-14); [T-345, 456-463].

9. The next day, June 5, 2002, Patient A told his attending physician, Dr. Sowinski that no physician examined him during his hospital stay other than the female doctor in the ER, and the vascular surgeon, Dr. Sheth, who had inserted a subclavian line that morning. Patient A gave Dr. Naing (medical director of the family health clinic of Mount Sinai Hospital) and Karen Kirschner (Mount Sinai Hospital's Risk Manager) the same account at a bedside interview on June 6, 2002 (Department's Exhibit # 3, p.18); [T-38, 239-240].

10. Dr. Naing questioned Respondent on the telephone regarding Patient A's assertion. Respondent denied Patient A's assertion that he did not examine Patient A, but said that he saw the patient briefly in the ER, looked at his legs, and listened to his heart and lungs [T-242].

11. At a meeting held at Mount Sinai Hospital on June 14, 2002 attended by Respondent, Arthur Gualtieri, M.D. (Mount Sinai Hospital's Medical Director), Bhupendra Patel, M.D. (Mount Sinai Hospital's Chief Of Medicine), and Ms. Kirschner, Respondent made the following admissions:

a. Respondent admitted that on June 4, 2002 he copied Patient A's temperature and blood pressure readings, taken three hours previously to Respondent's own physical examination forms for Patient A [T-137-139, 178].

b. Respondent admitted that he documented findings, in Patient A's medical records, for an abdominal examination of Patient A that Respondent did not perform [T-214].

c. Respondent admitted documenting "no lymphadenopathy" under the Lymphatic System Examination section of Patient A's medical records, when he did not examine the patient on any part of his body for lymph node swelling [T-139].

d. Respondent admitted documenting "normal male external genitalia" under the Urogenital Exam section of Patient A's medical records, when he did not examine Patient A's genitalia [T-139-140, 470-473].

12. Respondent acknowledged that he did not check Patient A's blood test results, available at 11:19 P.M. the evening of June 4, 2002, before prescribing 80 mg of gentamycin every 8 hours to Patient A [T-437-438, 432].

13. Respondent did not actually take a clinical history and perform a physical examination of Patient A [T-186-188, 315-486].

### **CONCLUSIONS OF LAW**

The Hearing Committee, pursuant to the Findings of Fact listed above, makes the conclusion by a unanimous vote, that Factual Allegations A., A.1 and A.1.a contained in the September 27, 2004 Statement of Charges are **SUSTAINED**. Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by a unanimous vote, concludes that the three Specifications of Misconduct contained in the Statement of Charges are **SUSTAINED**. The rationale for the Hearing Committee's conclusions is set forth below.

### **DISCUSSION**

Respondent is charged with three (3) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled: Definitions of Professional Misconduct under the New York Education Law<sup>7</sup>. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

Practicing the Profession Fraudulently

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Sookhu made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; (2) Dr. Sookhu knew that the representation was false; and (3) Dr. Sookhu intended to mislead through the false representation. The Hearing Committee is the sole arbiter of whether fraud occurred and must base its determination on the credible facts (including Respondent's testimony) and not on whether others believe that fraud occurred or did not occur.

The ALJ also instructed the Hearing Committee of the following commonly understood concepts:

Failure to Maintain Records

A physician must record meaningful and accurate information in a patient's medical records which accurately reflects the care and treatment of the patient for a number of reasons. These reasons include: (1) for the physician's own use; (2) for the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient.

---

<sup>7</sup> A copy was made available to both parties at the Pre-Hearing conference [P.H.T-4-6]; [T-4].

### Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence. The Hearing Committee understood that as the trier of fact we may accept so much of a witnesses' testimony as is deemed true and disregard what we find and determine to be false.

### Credibility

The Hearing Committee found the three witnesses presented by the Department, Dr. Gualtieri, Dr. Naing and Ms. Kirschner to be credible individuals and, as a group, consistent. We could not believe that all three of the Department's witnesses had ulterior motives or animus towards Respondent which would be strong enough to justify a string of lies or a conspiracy. We could not believe that Mount Sinai's Medical Director, the current Director of the Family Health Clinic, and the Risk Manager would form an elaborate scheme against Respondent including perjuring themselves on the record at a Department of Health Hearing. Dr. Patel's testimony, the fourth witness presented by the Department, was mostly irrelevant.

Respondent has the most at stake in this proceeding. Respondent's testimony was not consistent with his prior accounts of the events of June 4, 2002 to other individuals. Respondent's testimony was even contradictory and inconsistent at the Hearing. For example, Respondent first testified that he wrote "deferred" in the space provided on the medical records form for Patient A's rectal exam while Respondent was in the ER on the evening of June 4, 2002. Respondent said he did this due to privacy concerns. Respondent later testified that he wrote "deferred" the next morning, June 5, 2002, while in Patient A's hospital room. Both explanations of this notation can't be valid. The Hearing Committee concluded that Respondent fabricated his testimony when he deemed it necessary to do so. Another example was Respondent's ad hoc and obviously fabricated testimony regarding his examination (or view) of Patient A's genitalia. Another example was Respondent's claim of writing "at least a three line note" on page sixteen of Patient A's medical records documenting Patient A's irate state early in the morning on June 5, which precluded Respondent from performing a rectal examination. Respondent's claim that his note vanished is not believable.

Respondent's response to Dr. Gualtieri when asked if he had anything more to add to his explanation of the circumstance was that he "wanted to keep his job". Given the conversation and the information discussed between Dr. Gualtieri and Respondent, we find Respondent's response at the time of the conversation to be akin to an admission of guilt.

### Summary

The Hearing Committee believes that what Respondent recorded under the history and physical examination sections of Patient A's medical records was copied and otherwise gleaned from the patient's ER medical record, and supplemented by Respondent's brief and cursory visual impression of the patient. Respondent documented in Patient A's medical records that on June 4, 2002 he performed a complete examination of Patient A. On June 4, 2002 Respondent did not perform a complete examination of Patient A. Respondent knew that he did not perform a complete

examination of Patient A. Respondent intentionally indicated in Patient A's medical records that he had performed a complete medical examination in order to make it appear to others that he had done so. Respondent's representation was false and was done with the intention to mislead others.

Dr. Stephen Sowinski was Patient A's primary care physician. When, on June 5, 2002, Dr. Sowinski learned of a very serious problem regarding patient A's care, he not only brought it to the attention of the hospital's Medical Director, but he immediately documented the events in Patient A's medical records, including Patient A's assertion that Respondent did not examine him.

The Hearing Committee unanimously concludes that the Department has proven, by a preponderance of the evidence, that the charge that Respondent practiced the profession of medicine fraudulently should be sustained. The Hearing Committee also sustains the charge that Respondent committed professional misconduct by failing to maintain a record for Patient A which accurately reflects the care and treatment that Respondent provided to the patient.

Respondent falsely reported results of an examination he did not perform in Patient A's medical records, and did so willfully and voluntarily. Respondent acknowledged that he performed a complete medical examination as attested by his signature. We sustain the charge that Respondent committed professional misconduct by willfully making a false report.

In accordance with the above understanding, the Hearing Committee unanimously determined that all of the allegations and all of the charges contained in the Statement of Charges were established by a preponderance of the evidence.

## DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee determines that Respondent's license to practice medicine in New York State should be suspended for one (1) year. Respondent shall also be required to be on probation for three (3) years and have a Practice Monitor review his medical records as indicated in the annexed Terms of Probation. During the one year term of suspension Respondent must successfully complete at least fifty (50) hours of Continuing Medical Education ("CME") including courses on (1) medical ethics and (2) medical documentation and/or medical record keeping. These 50 hours of CME are in addition to any other required CME (which are taken to stay current in the practice of medicine) and must be approved by the Director of the Office of Professional Medical Conduct (or his designee). In addition, Respondent's license to practice medicine shall be limited for three (3) years with the requirement that Respondent only practice in a supervised setting such as an Article 28 facility.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including: (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The Hearing Committee extensively discussed the appropriate penalties necessary to address Respondent's misconduct in this case. In the final analysis the Hearing Committee had to decide on one of two options: either Respondent's license should be revoked, or Respondent's license should be suspended for a period of time and he should be placed on probation, with certain conditions including retraining and supervision in an Article 28 type facility.

The Hearing Committee understood that Respondent was in an Article 28 facility when the

misconduct occurred; however, Respondent's misconduct came to light mostly because he was practicing in a hospital and had peer review.

Respondent has accepted no responsibility for his actions. The Hearing Committee is concerned that Respondent will continue to take short cuts, be careless, and his deceptions will be repeated, and possibly place other patients and medical personnel at risk. Respondent has committed fraud. This act is a serious transgression as it belies a fundamental lack of integrity. Physicians are not infallible nor are they held to that standard; however, honesty and accountability are standards that are inviolate. Their breach corrupts the profession, endangers the public, and taints the trust that patients place in their physicians, an effect which cannot be minimized. Respondent's unacceptable practice led to a bad outcome for Patient A. The Hearing Committee believes that the penalty imposed should help prevent future unprofessional practice by Respondent. The Hearing Committee believes that Respondent can provide benefit to society with his medical license and with appropriate safeguards.

No additional fines or sanction were deemed appropriate under the circumstances presented. Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

## ORDER

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

1. The **FIRST, SECOND, and THIRD SPECIFICATIONS** contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and
2. All Factual Allegations contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and
3. Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED for ONE (1) YEAR**; and
4. Respondent shall be on **PROBATION for THREE (3) YEARS** and have a Practice Monitor review his medical records as indicated in the annexed terms of probation (Appendix 3) which terms are fully incorporated in this Determination and Order; and
5. The period of probation shall begin after the completion of Respondent's suspension; and
6. During the one year term of suspension Respondent must successfully complete at least fifty (50) hours of Continuing Medical Education ("CME") including courses on (1) medical ethics and (2) medical documentation and/or medical record keeping. These 50 hours of CME are in addition to any other required CME (which are taken to stay current in the practice of medicine) and must be approved by the Director of the Office of Professional Medical Conduct (or his designee);  
and

7. Respondent's license to practice medicine shall be limited for three (3) years to practice in a supervised setting such as an Article 28 facility. The period of limitation shall begin after the completion of Respondent's suspension; and

8. 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 by certified mail or as provided by P.H.L. §230(10)(h).

**DATED: New York  
March, 23 2005**



**DAVID HARRIS, M.D., M.P.H. (CHAIRPERSON)  
ROBERT SCHILLER, M.D.  
CARMELA TORRELLI**

**Lloyd Ramraj Sookhu, M.D.  
164 Weeks Drive  
Dix Hills, NY 11746**

**Podlofsky, Orange & Kolenovsky  
Ira Podlofsky, Esq.  
98 Cutter Mill Road, #299-N  
Great Neck, NY 11021**

**Christine M. Radman, Esq.  
Assistant Counsel  
New York State Department of Health  
Office of Professional Medical Conduct  
90 Church Street, 4<sup>th</sup> Floor  
New York, NY 10007-2919**

# APPENDIX 1

**IN THE MATTER**  
**OF**  
**LLOYD RAMRAJ SOOKHU, M.D.**

**STATEMENT**  
**OF**  
**CHARGES**

Lloyd Ramraj Sookhu, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 2, 1990, by the issuance of license number 182495 by the New York State Education Department. Respondent is currently registered to practice medicine with the New York State Department of Health from December 2002 through November 2004.

**FACTUAL ALLEGATIONS**

- A. Respondent treated Patient A (identified in the attached appendix) on or about June 4, 2002 in his capacity as House Physician at The Mount Sinai Hospital of Queens Emergency Department, located in Long Island City, N.Y.
  - 1. Respondent falsely documented in Patient A's medical chart that he performed a complete examination, when in fact he did not perform a complete examination.
    - a. Respondent did so knowingly and with intent to deceive.

**SPECIFICATION OF CHARGES**

~~FIRST AND SECOND SPECIFICATIONS~~  
**FRAUDULENT PRACTICE**

11/9/4  
MPZ

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

alleged in the facts of the following:

1. Paragraph A, A1, and A1a.

~~SECOND~~  
~~THIRD~~ SPECIFICATION  
FAILURE TO MAINTAIN RECORDS

11/9/04  
M12

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 care and treatment of the patient, as alleged in the facts of:

3. Paragraph A and A1.

~~THIRD~~  
~~FOURTH AND FIFTH~~ SPECIFICATIONS  
FALSE REPORT

11/9/4  
M12

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

4. Paragraph A, A1, and A1a.

DATED:

Sept 27  
July 18, 2004  
New York, New York



Roy Nemerson  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

# APPENDIX 2

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

-----X

ANSWER

IN THE MATTER OF  
LLOYD RAMRAJ SOOKHU, M.D.

-----X  
COUNSEL:

Respondent, LLOYD RAMRAJ SOOKHU, M.D., by his attorneys, PODLOFSKY ORANGE & KOLENOVSKY, in answer to the allegations in the Department of Health's Statement of Charges, respectfully alleges, upon information and belief, as follows:

**FACTUAL ALLEGATIONS**

1. Denies the allegations contained in the "Factual Allegations" paragraphs ~~1~~, "A1", and "A1(a)" of the Statement of Charges;

**SPECIFICATIONS OF CHARGES**

**FIRST AND SECOND SPECIFICATIONS**

**FRAUDULENT PRACTICE**

2. Respondent repeats, reiterates and realleges each and every defense contained in paragraph "1" above as if fully set forth herein with the same force and effect.
3. Denies the allegations contained in the "First and Second Specifications: Fraudulent Practice" paragraph of the Statement of Charges;

**THIRD SPECIFICATION**

**FAILURE TO MAINTAIN RECORDS**

4. Respondent repeats, reiterates and realleges each and every defense contained in paragraphs "1" through "3" above as if fully set forth herein with the same force and effect.
5. Denies the allegations contained in the "Third Specification: Failure to Maintain Records" paragraph of the Statement of Charges;

**FOURTH AND FIFTH SPECIFICATIONS  
FALSE REPORT**

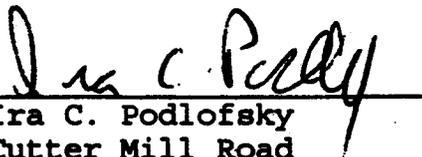
6. Respondent repeats, reiterates and realleges each and every defense contained in paragraphs "1" to "5" above as if fully set forth herein with the same force and effect.
  
7. Denies the allegations contained in the "Fourth and Fifth Specifications: False Report" paragraph of the Statement of Charges;

WHEREFORE, respondent demands judgment dismissing the Statement of Charges, and for such other and further relief as the Board may deem just and proper.

Dated: Great Neck, New York  
October 5, 2004

Yours, etc.,

PODLOFSKY ORANGE & KOLENOVSKY  
Attorneys for Respondent  
LLOYD RAMRAJ SOOKHU, M.D.

By:   
Ira C. Podlofsky  
98 Cutter Mill Road  
Suite 299N  
Great Neck, New York 11021  
(516) 487-7300

TO: Hon. Sean D. O'Brien,  
Director, Bureau of Adjudication  
Bureau of Adjudication  
Hedley Park Place  
433 River Street  
Fifth Floor South  
Troy, NY 12180  
(518) 402-0748

Roy Nemerson, Deputy Counsel  
Christine M. Radman, Assistant Counselor  
New York State Health Department  
Bureau of Professional Medical Conduct  
5 Penn Plaza  
New York, NY 10001  
(212) 268-6806

# APPENDIX 3

## **Terms of Probation for Lloyd Ramraj Sookhu, M.D.**

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and 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 Determination and 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. 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 staff at practice locations or OPMC offices.

6. 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.

7. Respondent shall enroll in and successfully complete at least fifty (50) hours of a Continuing Medical Education program in the area of (1) medical ethics and (2) medical documentation and/or medical record keeping. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the first year prior to the beginning of probation.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("Practice Monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

9. Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the monitor, including on-site observation. The Practice Monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 10) of records maintained by Respondent, including patient records and prescribing information. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

11. Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

12. Respondent shall maintain or be covered by medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order

13. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. On 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.