



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Public

Richard F. Daines, M.D.
Commissioner
NYS Department of Health
James W. Clyne, Jr.
Executive Deputy Commissioner
Keith W. Servis, Director
Office of Professional Medical Conduct

Kendrick A. Sears, M.D.
Chair
Carmela Torrelli
Vice Chair
Katherine A. Hawkins, M.D., J.D.
Executive Secretary

July 14, 2010

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Mehran Zadeh, R.P.A.

REDACTED

RE: License No. 003399

Dear Mr. Zadeh:

Enclosed is a copy of Modification Order BPMC #10-101 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect July 21, 2010.

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1717
Empire State Plaza
Albany, New York 12237

Sincerely,

REDACTED

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

cc: Kurt E. Lundgren, Esq.
Thwaites & Lundgren
3 West Main Street - Suite 205
Elmsford, NY 10523

IN THE MATTER
OF
MEHRAN ZADEH, R.P.A.

MODIFICATION
ORDER

BPMC No. #10-101

Upon the proposed Application for a Modification Order of MEHRAN ZADEH, R.P.A. (Respondent), which is made a part of this Modification Order, it is agreed to and

ORDERED, that the attached Application and its terms are adopted and it is further

ORDERED, that this Modification Order shall be effective upon issuance by the Board, either by mailing of a copy of this Modification Order by first class mail to Respondent at the address in the attached Application or by certified mail to Respondent's attorney, OR upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 7-14-2010

REDACTED

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER
OF
MEHRAN ZADEH, R.P.A.

APPLICATION FOR
MODIFICATION
ORDER

STATE OF NEW YORK)
COUNTY OF) ss.:

MEHRAN ZADEH, R.P.A., (Respondent) being duly sworn, deposes and says:

That on or about October 19, 1987, I was authorized to practice as a physician assistant in New York State by the issuance of license number 003399 the New York State Education Department.

My current address is REDACTED and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I am currently subject to BPMC Determination and Order # BPMC 10-101 (Attachment I) (henceforth "Original Order"), which was issued on or about June 11, 2010, by a Hearing Committee of the State Board for Professional Medical Conduct, after a disciplinary hearing was held, and the First through Twentieth Specifications of misconduct contained in the Statement of Charges were sustained (the Twenty-First through Twenty-sixth Specifications of misconduct were not sustained.) I hereby apply to the State Board for Professional Medical Conduct for an Order (henceforth "Modification Order"), modifying the Original Order, as follows:

The sanction imposed in the Original Order was:

Respondent's license to practice as a physician assistant in New York State be and hereby is **SUSPENDED** for a period of **THREE (3) YEARS**, said suspension to be **STAYED in its entirety**;

Respondent's license shall be placed on **PROBATION** during the suspension period, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order, and

Respondent shall refrain from ordering, performing and/or interpreting electrodiagnostic nerve and muscle studies from this Order's effective date and continuing as long as Respondent remains a licensee in New York State; and

Respondent is assessed a civil penalty in the amount of **SEVEN THOUSAND FIVE HUNDRED DOLLARS (\$7,500)**.

Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of laws relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); state Finance Law, section 18; CPLR, section 50001. Executive Law, section 32.)

The sanction imposed shall be modified so as to include the originally imposed terms (as set forth above) and, in addition, the following term, which shall henceforth be Term of Probation 10 in Appendix II (2) (i.e., the Terms of Probation):

- 10 Within thirty days of the effective date of this Modification Order, Respondent shall practice as a physician assistant only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the prior written approval of the Director of OPMC. Any practice as a physician assistant in violation of this term shall constitute the unauthorized practice of the profession.
 - a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each

and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's practice as a physician assistant is conducted in accordance with the generally accepted standards of professional care. Any perceived deviation of accepted standards of care, or refusal to cooperate with the monitor, shall be reported within 24 hours to OPMC.

- b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
- c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
- d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with N.Y. Pub. Health Law § 230(18)(b). Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

and

• All remaining Terms and Conditions will continue as written in the Original Order.

I make this Application of my own free will and accord and not under duress, compulsion or restraint, and seek the anticipated benefit of the requested Modification. In consideration of the value to me of the acceptance by the Board of this Application, I knowingly waive my right to contest the Original Order or the Modification Order for which I apply, whether administratively or judicially, and ask that the Board grant this Application.

I understand and agree that the attorney for the Bureau of Professional Medical Conduct, the Director of the Office of Professional Medical Conduct and the Chair of the State Board for Professional Medical Conduct each retain complete

discretion either to enter into the proposed agreement and Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

I understand that, upon issuance of the Modification Order for which I apply, the Department shall withdraw its pending appeal of the Original Order to the Administrative Review Board.

DATE: 7-1-10

REDACTED

MEHRAN ZADEH, R.P.A.
RESPONDENT

The undersigned agree to Respondent's attached Application and to the proposed penalty based on its terms and conditions.

DATE: 7-1-10

REDACTED

~~_____~~
KURT E. LUNDGREN, ESQ.
Attorney for Respondent

DATE: 7/1/2010

REDACTED

~~_____~~
CHRISTINE RADMAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 7/13/10

REDACTED

~~_____~~
KEITH W. SERVIS
Director
Office of Professional Medical Conduct



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299



Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 11, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Mehran Zadeh, R.P.A.
REDACTED

Kurt E. Lundgren, Esq.
Thwaites & Lundgren
3 West Main Street – Suite 205
Elmsford, New York 10523

Christine Radman, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Mehran Zadeh, R.P.A.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-101) 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.

Payment of the civil penalty shall be made within thirty (30) days of the date of this letter

MAIL PAYMENT TO:

New York State Department of Health
Bureau of Accounts Management
Corning Tower Building-Room 1717
Empire State Plaza
Albany, New York 12237

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., 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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER
OF
MEHRAN ZADEH, R.P.A.

DETERMINATION
AND
ORDER

BPMC #10-101

COPY

Zoraida Navarro, M.D. (Chair), Paul Twist, M.D., and James J. Ducey, D.A., 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.

Christine C. Traskos, Esq., Administrative Law Judge, ("ALJ") served as the Administrative Officer. The Department of Health appeared by Christine Radman, Esq., Associate Counsel. Respondent, Mehran Zadeh, R.P.A., appeared personally and was represented by Thwaites & Lundgren, Kurt E. Lundgren, Esq. and Anthony Mamo, 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:	November 30, 2009
Date of Answer to Charges:	January 3, 2010
Date of Pre-hearing Conference	January 7, 2010
Hearings Dates:	February 4, 2010 March 9, 2010

Location of Hearing:	Offices of New York State Department of Health 90 Church Street New York, NY
Witnesses called by the Department of Health:	Joseph Feinberg, M.D. Joseph L. Cain, RN, M.P.H.
Witnesses called by the Respondent:	Mehran Zadeh, R.P.A.
Department's Proposed Findings of Fact, Conclusions of Law, and Sanction:	Received April 21, 2010
Respondent's Proposed Findings of Fact, Arguments, and Conclusion:	Received April 21, 2010
Deliberations Held:	April 29, 2010

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. Mehran Zadeh, R.P.A., ("**Respondent**") is charged with twenty-six (26) 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: practicing the profession of medicine with incompetence on more than one occasion; practicing the profession of medicine with negligence on more than one occasion; ordering unwarranted tests or treatment; failing to maintain a record for each patient which accurately reflects the care and treatment of that patient; practicing his profession beyond the scope permitted by law and improper delegation of professional

responsibilities. The charges are more specifically set forth in the Statement of Charges, dated November 30, 2009, a copy of which is attached as Appendix I and made a part of this Determination and Order. Respondent denies all factual allegations and all specifications of misconduct contained in the Statement of Charges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee. 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 Petitioner, which has the burden of proof, was required to prove its case by a preponderance of the evidence.

All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.¹

1. Respondent was authorized to practice as a physician assistant in New York State on or about October 19, 1987 by the issuance of license number 003399 by the New York State Education Department (Pet.'s Ex. 1).

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 (P.H.L. §230[10][d]). (Pre-hearing transcript 1/07/10)

PATIENTS A through F

3. From on or about July 27, 2006 through on or about January 9, 2007, Respondent evaluated Patients A through F in "follow up" neurological examinations and electrodiagnostic

¹ Numbers in parentheses refer to Hearing transcript page numbers (T.). "Ex." refers to exhibits admitted into evidence by Petitioner (Pet.) or Respondent (Resp.).

testing, in his capacity as physician assistant to Colin Clarke, M.D.

4. Patients A through F were each involved in motor vehicle accidents, after which they were examined by Dr. Clarke. Each were then referred to ELS Medical Services, P.C., which was solely owned by Dr. Clarke, for "follow up" neurological examinations and electrodiagnostic testing (EDX). Respondent evaluated and treated each patient. (Pet. 4, pp. 39-41, Pet. 5, pp. 39-41, Pet. 6, pp. 60-62, Pet. 7, pp. 46-48, Pet. 8, pp. 48-50, Pet. 9, pp. 40-42; T. p. 384-387, 392)

5. Peripheral electrodiagnostic testing studies the electrophysiology of nerve tissue, muscle tissue and the neuromuscular juncture, which is the interface between the peripheral nerve and the muscle, in patients with neurological deficits. They are comprised of nerve conduction studies (NCS), where electrical current is used to stimulate both motor and sensory nerves, and electromyography (EMG) of muscles, commonly referred to as the needle exam. (T. pp. 23-28)

6. EDX is sophisticated testing requiring specific training and skill to accomplish effectively and thereby obtain meaningful diagnostic information. Thorough understanding of neurophysiology, proper and well maintained equipment and adequate technique are essential. This is especially true of the needle portion, which is a real time, dynamic test yielding both visual and aural data and is interpreted as it proceeds. Clinical judgment comes to bear when performing the test to determine if findings suggest further muscle testing. (T. pp. 34-44)

7. Respondent had no formal training in EDX nor does he possess sufficient knowledge of neurophysiology to order and perform EDX. (T. p. 400, 456-469, 494-496, 506-508)

8. Dr. Clarke's initial examinations of Patients A through F consistently document no gross neurological abnormalities or fails to document any neurological examination. (Pet. 4, p.7, Pet. 5, p. 6, Pet. 6, p. 7, Pet. 7, p. 6, Pet. 8, p. 6, Pet. 9, p. 5-7; T. p. 65)

9. Respondent was directed by Dr. Clarke to perform follow up examinations of Patients A through F, and Respondent consistently documented neurological deficits. Respondent failed to

document any medical explanation for such deteriorations or any consultation with his supervising physician regarding the clinical changes. It is a deviation from the standard of care to appreciate a neurological deterioration in a motor vehicle accident patient and fail to seek a medical explanation for it and adjust treatment protocols accordingly. (Pet. 4, pp. 39-41, Pet. 5, pp. 39-41, Pet. 6, pp. 60-62, Pet. 7, pp. 46-48, Pet. 8, pp. 48-50, Pet. 9, pp. 40-42; T. pp. 75-76, 424-425)

10. Respondent consistently failed to perform motor examinations and/or performed inadequate motor examinations on Patients A through F, which is a critical part of any neurological examination. (Pet. 4, p. 40, Pet. 5, p. 40, Pet. 6, p. 61, Pet. 7, p. 47, Pet. 8, p. 49, Pet. 9, p. 41; T. pp. 71-72, 131-132) Respondent ordered and performed EDX on Patients A through F based upon inadequate neurological examinations. These practices deviate from the standard of care. (T. pp. 74-75, 295-297)

11. Colin Clarke, M.D. is board certified in Nuclear Medicine with no formal training in EDX (neither nerve conduction nor electromyography). He is not a practicing neurologist, physiatrist nor sports medicine physician, therefore electromyography (EMG) is not within his scope of practice. (T. p. 275, 320-321)

12. New York State law states that a physician assistant may perform medical services only when under the supervision of a physician and only when such acts and duties are within the scope of the supervising physician's practice. In addition, the physician assistant needs the proper training to perform the particular medical service in question. (Resp. C and E)

13. Respondent deviated from the standard of care by performing EMG (needle) tests on Patients A through F, which were not within the scope of his supervising physician's practice nor was Respondent properly educated and trained to perform them. (T. pp. 56-58, 121, 460-467, 494-496)

14. Respondent ordered and performed medically unwarranted EDX by testing all four

limbs of Patients A through F with EMG, which was not indicated given the patients' presenting complaints, and therefore a deviation from the standard of care. (Pet. 4, pp. 28, 33, Pet. 5, pp. 31, 36, Pet. 6, pp. 49, 54, Pet. 7, pp. 38, 43, Pet. 8, pp. 40, 45, Pet. 9, pp. 33, 37; T. pp. 56-58, 80)

15. A physician may refer a patient to another medical professional for neurological testing (EDX), but such testing shall only then be ordered and performed by the referred medical professional if it is medically necessary. (T. 146-147)

16. Respondent ordered the testing of superficial radial sensory and saphenous sensory nerves, which were not indicated by the patients' conditions. Respondent, as physician assistant to Colin Clarke, M.D., directed a technician to perform medically unnecessary nerve conduction studies for Patients A through F. These tests are not normally performed in a routine nerve conduction study. (Pet. 4, pp. 27-30, 32-35, Pet. 5, pp. 30-33, 35-38, Pet. 6, pp. 48-51, 53-56, Pet. 7, pp. 37-40, 42-45, Pet. 8, pp. 39-42, 44-47, Pet. 9, pp. 31-34, 36-39; T. pp. 79-80, 172-173)

17. Respondent failed to document and appreciate abnormal nerve conduction test results for Patients A through F. He similarly failed to comment on or re-test nerves, the results for which showed technical flaws thereby yielding no meaningful diagnostic data. (Pet. 4, pp. 27-30, 32-35, Pet. 5, pp. 30-33, 35-38, Pet. 6, pp. 48-51, 53-56, Pet. 7, pp. 37-40, 42-45, Pet. 8, pp. 39-42, 44-47, Pet. 9, pp. 31-34, 36-39; T. pp. 79-96)

18. Colin Clarke, M.D. entered into a Consent Agreement with the Office of Professional Medical Conduct grounded in "negligence on more than one occasion" for failing to adequately supervise the performance, evaluation and documentation of examinations and electrodiagnostic tests by members of his staff. Respondent was Dr. Clarke's physician assistant, to whom these medical examinations and tests were delegated. (Pet. 3, pp. 9-10, T. pp. 283-284)

19. Respondent had no written practice agreement with his supervising physician. Dr. Clarke participated in an OPMC interview conducted by Joseph Cain on May 29, 2008. At that

interview, he gave the first name of his physician assistant as "Raminder" and could not recall his last name. Dr. Clarke subsequently provided Mr. Cain with his physician assistant's CV, which identified "Mehran Zadeh" as his physician assistant. (T. pp. 276, 299, 310)

20. Respondent admitted that he was not adequately supervised by Dr. Clarke when he treated Patients A through F. (T. pp. 388-391)

21. Respondent recommended the continuation of physical therapy for Patients A through F based on EDX findings that had no diagnostic value due to flawed technical performance as well as EDX documented abnormal findings that were clinically unaddressed, thereby deviating from the standard of care. (Pet. 4, p. 41, Pet. 5, p. 41, Pet. 6, p. 62, Pet. 7, p. 48, Pet. 8, p. 50, Pet. 9, p. 42; T. pp. 93-94)

22. Respondent failed to maintain a record for Patients A through F which accurately reflects the care and treatment of those patients and his record keeping deviated from minimally acceptable standards of record keeping. He did not adequately document his examination of Patients A through F. (Pet. 4, pp. 39-41, Pet. 5, pp. 39-41, Pet. 6, pp. 60-62, Pet. 7, pp. 46-48, Pet. 8, pp. 48-50, Pet. 9, pp. 40-42; T. pp. 77)

CONCLUSIONS OF LAW

Respondent is charged with twenty-six (26) 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. During the course of their 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, incompetence and the fraudulent practice of medicine.

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

Negligence on More Than One Occasion

Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by the Respondent caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

Incompetence on More Than One Occasion

Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning. These factors may include the Hearing Committee's impression of Respondent's technical knowledge and competence on the various issues and the charges under consideration.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by preponderance of the evidence, that twenty (20) out twenty-six (26) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the various witnesses presented by the parties. The Committee must determine the

credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

With regard to the testimony presented, the Hearing Committee evaluated all witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, and demeanor.

The Department offered Joseph Feinberg, M.D. as their expert witness. Dr. Feinberg is a double Board-certified physiatrist in Electrodiagnostics and Sports Medicine. He is a fellow of the American Associate of Neuromuscular Electrodiagnostic Medicine(AANEM). At present, Dr. Feinberg is the Vice Chair of the Department of Physiatry, Director of the Electrodiagnostics Lab and Fellowship Director at the Hospital for Special Surgery (HSS). In addition to his teaching responsibilities at the HSS, he is extensively published and provides direct patient care.(Pet. Ex.10) The Hearing Committee found Dr. Feinberg to be well known and well qualified in EMGs and that he spoke from a wealth of knowledge. The Hearing Committee found Dr. Feinberg's testimony to be very credible on the records he reviewed. They also note that to his credit Dr. Feinberg acknowledged up front when he was unfamiliar with an issue.

The Department also offered the testimony of Joseph Cain, R.N. who recently retired from the Office of Professional Medical Conduct where he had been employed for eleven years in the Medical Fraud Unit. (T. 272) The Hearing Committee notes that Mr. Cain's testimony shed some

light on the lack of professional relationship between Respondent and Dr. Clarke. Overall they found that his testimony was not relevant to the Charges.

Respondent testified on his own behalf. The Hearing Committee finds that Respondent misrepresented his level of skill and training in the answers that he provided at the hearing. Many of his answers were not straightforward and he had to be pressed by the Chair to answer the question directly.(T. 454-469) As a result, the Hearing Committee gave Respondent's testimony little weight.

PATIENTS A through F

Factual Allegations A and A.1: Sustained
Factual Allegations A and A.2: Not Sustained
Factual Allegations A and A.3: Sustained
Factual Allegations A and A.4: Sustained (except with respect to "Ordered")
Factual Allegations A and A.5: Not Sustained
Factual Allegations A and A.6 : Sustained
Factual Allegations A and A.7: Sustained

Factual Allegations B and B.1: Sustained
Factual Allegations B and B.2: Not Sustained
Factual Allegations B and B.3: Sustained
Factual Allegations B and B.4: Sustained (except with respect to "Ordered")
Factual Allegations B and B.5: Not Sustained
Factual Allegations B and B.6 : Sustained
Factual Allegations B and B.7: Sustained

Factual Allegations C and C.1: Sustained
Factual Allegations C and C.2: Not Sustained
Factual Allegations C and C.3: Sustained
Factual Allegations C and C.4: Sustained (except with respect to "Ordered")
Factual Allegations C and C.5: Not Sustained
Factual Allegations C and C.6 : Sustained
Factual Allegations C and C.7: Sustained

Factual Allegations D and D.1: Sustained
Factual Allegations D and D.2: Not Sustained
Factual Allegations D and D.3: Sustained
Factual Allegations D and D.4: Sustained (except with respect to "Ordered")
Factual Allegations D and D.5: Not Sustained
Factual Allegations D and D.6 : Sustained
Factual Allegations D and D.7: Sustained

Factual Allegations E and E.1: Sustained
Factual Allegations E and E.2: Not Sustained
Factual Allegations E and E.3: Sustained
Factual Allegations E and E.4: Sustained (except with respect to "Ordered")
Factual Allegations E and E.5: Not Sustained
Factual Allegations E and E.6 : Sustained
Factual Allegations E and E.7: Sustained

Factual Allegations F and F.1: Sustained
Factual Allegations F and F.2: Not Sustained
Factual Allegations F and F.3: Sustained
Factual Allegations F and F.4: Sustained (except with respect to "Ordered")
Factual Allegations F and F.5: Not Sustained
Factual Allegations F and F.6 : Sustained
Factual Allegations F and F.7: Sustained

INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee notes that Respondent testified that he did not perform any nerve conduction studies for Patients A through F. Respondent stated that he only performed the electromyography (EMG) needle tests. (T. 363-364) The Hearing Committee therefore construes that the Charges referring to nerve testing apply to EMG testing.

The Hearing Committee concurs with Dr. Feinberg that EMG testing requires knowledge of neurophysiology and is a real time dynamic testing situation. (T. 40-44) The Hearing Committee finds that Respondent demonstrated his lack of skill for the testing he performed in the answers he provided to Hearing Committee questions. He could not explain the inconsistencies between his findings and Dr. Clark's and he could not adequately locate the brachial plexus for the Committee. (T. 457-466; 494-496). The Hearing Committee concludes that Respondent performed the testing in a robotic fashion without understanding what he was doing. As a result, the Hearing Committee sustains the First Specification.

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent acknowledged at the hearing that while he had been appropriately trained to

assist another physician in the performance of electrodiagnostic testing, he was not trained to perform the test alone. (T. 467) The Hearing Committee finds that since Respondent knew he did not possess the requisite skill level, it was careless of him to perform these tests on Patients A through F. The Hearing Committee finds Respondent was negligent and sustains the Second Specification.

UNWARRANTED TESTS /TREATMENT

Based on the testimony of Dr. Feinberg and an independent review of the medical records, the Hearing Committee finds that there was no justification to test all of the patients' extremities in absence of a motor exam or where there were asymptomatic findings. The Hearing Committee sustains the Third through Eighth Specifications.

FAILURE TO MAINTAIN RECORDS

The Hearing Committee, after a thorough review of the records, finds that Respondent failed to maintain a record for each patient which accurately reflects the care and treatment of the patient. The Ninth through Fourteenth Specifications are sustained.

PRACTICING BEYOND THE SCOPE

Respondent acknowledged in his testimony that he did not perform EMG's when he was employed at New York Physical Medicine and Rehab as well as at his current job at Westchester Medical. In each instance he stated that he only assists or monitors while the physicians perform the EMGs. (T. 362-367) The Hearing Committee is troubled by Respondent's argument that he "could not possibly have known at the time that he was hired at ELS Medical that he would be working for a doctor that had no formal training in electrodiagnostic medicine..." (Resp.'s brief p. 2) The Hearing Committee concludes that the Respondent was required by law to know the scope of practice of the supervising physician. The Hearing Committee sustains Specifications Fifteen through Twenty.

IMPROPER DELEGATION OF PROFESSIONAL RESPONSIBILITIES

The Hearing Committee does not sustain Specifications Twenty-One through Twenty-Six because there is no proof in the record that Respondent was responsible to supervise the technician.

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, by unanimous vote, determines that Respondent's license to practice medicine in New York State should be suspended for a period of three (3) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on a general probation with the requirement that he permanently be restricted from ordering, performing and/or interpreting electrodiagnostic nerve and muscle studies. Respondent will also be assessed a civil penalty of \$7,500. The complete terms of probation are attached to this Determination and Order as Appendix II. 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, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee believes that the penalty requested by the Department is more restrictive than the penalty agreed to for Dr. Clark and would be tantamount to a revocation. Dr. Clark was not trained to do EMGs and he should not have delegated this responsibility to a physician assistant. Respondent, however, had the responsibility to question the type of testing Dr. Clark requested him to do when all of the patients physical findings did not support this. Instead Respondent acted like a technician and blindly performed the tests.

Although the Hearing Committee found that Respondent was not forthcoming with his answers to technical questions, the Hearing Committee believes that Respondent was remorseful and he did accept responsibility for his conduct. The Hearing Committee believes that this penalty will

encourage Respondent to exercise better clinical judgment and make certain that he is clear about the scope of practice of his employer physician. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The First through Twentieth Specifications of misconduct contained in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**; and
2. The Twenty-First through Twenty-Sixth Specifications of misconduct contained in the Statement of Charges (Petitioner's Exhibit # 1) are **NOT SUSTAINED**; and
3. Respondent's license to practice as a physician assistant in New York State be and hereby is **SUSPENDED** for a period of **THREE (3) YEARS**, said suspension to be **STAYED in its entirety**; and
4. Respondent's license shall be placed on **PROBATION** during the suspension period, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and
5. Respondent shall refrain from ordering, performing and/or interpreting electrodiagnostic nerve and muscle studies from this Order's effective date and continuing as long as Respondent remains a licensee in New York State; and
6. Respondent is assessed a civil penalty in the amount of **SEVEN THOUSAND FIVE HUNDRED DOLLARS (\$7,500.00)**; and

7. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of laws relating to debt collection by the state of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; and non-renewal of permits or licenses (Tax Law, section 171(27); state Finance Law, section 18; CPLR, section 5001; Executive Law, section 32); 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, New York

June 10, 2010

REDACTED

Zoraida Navarro, M.D., (Chairperson)
Paul F. Twist, Jr. D.O.
James J. Ducey

Mehran Zadeh, R.P.A.

REDACTED

Kurt E. Lundgren, Esq.
Thwaites & Lundgren
3 West Main Street, Suite 205
Elmsford, NY 10523

Christine Radman, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street- 4th Floor
New York, NY 10007

APPENDIX 1

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

EXHIBIT
1 (50)
1-7-10 MW
PENGAD 800-631-4

IN THE MATTER
OF
MEHRAN ZADEH, RPA,

NOTICE
OF
HEARING

TO: MEHRAN ZADEH, RPA
REDACTED

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 January 5th, 2010, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, N.Y., N.Y. 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

/

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

Department attorney: Initial here _____

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, 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: New York, New York
November 30, 2009

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Christine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street, N.Y., N.Y. 10007
(212) 417-4450

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name _____ Date of Proceeding _____

Name of person to be admitted _____

Status of person to be admitted _____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

Signature (of licensee or licensee's attorney) _____

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

IN THE MATTER
OF
MEHRAN ZADEH, RPA

STATEMENT
OF
CHARGES

MEHRAN ZADEH, RPA, the Respondent, was authorized to practice as a physician assistant in New York State on or about October 19, 1987, by the issuance of license number 003399 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. On or about July 27, 2006, Respondent evaluated Patient A at offices located at 3924 East Tremont Avenue, Bronx, N.Y. for injuries reportedly sustained in a June 21, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient A on July 11, 2006. Respondent deviated from minimally accepted standards of care in that he:
1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient A as it relates to diagnosis and continuing treatment,
 2. Ordered nerve testing for Patient A not warranted by the patient's condition,
 3. Inappropriately performed and interpreted nerve testing,
 4. Ordered and conducted nerve testing for Patient A which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
 5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
 6. Recommended continued physical therapy based upon flawed and

misinterpreted nerve tests and

7. Failed to maintain a record that accurately reflects the evaluation of Patient A.

B. On or about August 11, 2006, Respondent treated Patient B at offices located at 3003 Avenue K, Brooklyn, N.Y. for injuries reportedly sustained in a July 12, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient B on July 14, 2006. Respondent deviated from minimally accepted standards of care in that he:

1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient B as it relates to diagnosis and continuing treatment,
2. Ordered nerve testing for Patient B not warranted by the patient's condition,
3. Inappropriately performed and interpreted nerve testing,
4. Ordered and conducted nerve testing for Patient ^B~~A~~ ^{CT 2/4/10} which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
6. Recommended continued physical therapy based upon flawed and misinterpreted nerve tests and
7. Failed to maintain a record that accurately reflects the evaluation of Patient B.

C. On or about August 17, 2006, Respondent treated Patient C at offices located at 3924 East Tremont Avenue, Bronx, N.Y. for injuries reportedly sustained in a June 23, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient C on July 6, 2006.

Respondent deviated from minimally accepted standards of care in that he:

1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient C as it relates to diagnosis and continuing treatment,
2. Ordered nerve testing for Patient C not warranted by the patient's condition,
3. Inappropriately performed and interpreted nerve testing,
4. Ordered and conducted nerve testing for Patient ^C~~A~~ ^{Oct 24/06} which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
6. Recommended continued physical therapy based upon flawed and misinterpreted nerve tests and
7. Failed to maintain a record that accurately reflects the evaluation of Patient C.

D. On or about September 8, 2006, Respondent treated Patient D at offices located at 3003 Avenue K, Brooklyn, N.Y. for injuries reportedly sustained in a July 12, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient D on July 17, 2006.

Respondent deviated from minimally accepted standards of care in that he:

1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient D as it relates to diagnosis and continuing treatment,
2. Ordered nerve testing for Patient D not warranted by the patient's condition,
3. Inappropriately performed and interpreted nerve testing,

7

D ^{cc} 2/4/10

4. Ordered and conducted nerve testing for Patient ~~A~~ which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
6. Recommended continued physical therapy based upon flawed and misinterpreted nerve tests and
7. Failed to maintain a record that accurately reflects the evaluation of Patient D.

E: On or about September 20, 2006, Respondent treated Patient E at offices located at 3003 Avenue K, Brooklyn, N.Y. for injuries reportedly sustained in an August 6, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient E on August 10, 2006. Respondent deviated from minimally accepted standards of care in that he:

1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient E as it relates to diagnosis and continuing treatment,
2. Ordered nerve testing for Patient E not warranted by the patient's condition,
3. Inappropriately performed and interpreted nerve testing,
4. Ordered and conducted nerve testing for Patient ~~A~~ which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
6. Recommended continued physical therapy based upon flawed and misinterpreted nerve tests and

E ^{cc} 2/4/10

7. Failed to maintain a record that accurately reflects the evaluation of Patient E.
- F. On or about January 9, 2007, Respondent treated Patient F at offices located at 3003 Avenue K, Brooklyn, N.Y. for injuries reportedly sustained in a December 7, 2006 motor vehicle accident. The physician for whom Respondent worked initially evaluated Patient F on December 7, 2007. Respondent deviated from minimally accepted standards of care in that he:
1. Failed to evaluate the clinical significance of the substantial differences in findings between the two examinations of Patient F as it relates to diagnosis and continuing treatment,
 2. Ordered nerve testing for Patient F not warranted by the patient's condition,
 3. Inappropriately performed and interpreted nerve testing,
 4. Ordered and conducted nerve testing for Patient ~~A~~^F which Respondent knew or had reason to know that he was not competent and/or inadequately supervised to undertake,
 5. Improperly delegated professional responsibilities to a technician not qualified to perform them,
 6. Recommended continued physical therapy based upon flawed and misinterpreted nerve tests and
 7. Failed to maintain a record that accurately reflects the evaluation of Patient F.

SPECIFICATION OF CHARGES

FIRST 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 two or more of the following:

1. Paragraphs A through F and each of their subparagraphs except subparagraphs 7 for each.

SECOND 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 two or more of the following:

2. Paragraphs A through F and each of their subparagraphs.

THIRD THROUGH EIGHTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

3. Paragraph A and A2.
4. Paragraph B and B2.
5. Paragraph C and C2.
6. Paragraph D and D2.
7. Paragraph E and E2.
8. Paragraph F and F2.

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

9. Paragraph A and A7.
10. Paragraph B and B7.
11. Paragraph C and C7.
12. Paragraph D and D7.
13. Paragraph E and E7.
14. Paragraph F and F7.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS
PRACTICING BEYOND THE SCOPE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(24) by practicing beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he is not competent to perform or performing without adequate supervision as alleged in the facts of:

15. Paragraph A and A4.
16. Paragraph B and B4.
17. Paragraph C and C4.
18. Paragraph D and D4.
19. Paragraph E and E4.
20. Paragraph F and F4.

TWENTY-FIRST THROUGH TWENTY-SIXTH SPECIFICATIONS
IMPROPER DELEGATION OF PROFESSIONAL RESPONSIBILITIES

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(25) by delegating his professional responsibilities in the ordering and performance of neurodiagnostic tests to a technician, as alleged in

the facts of:

21. Paragraph A and A5.
22. Paragraph B and B5.
23. Paragraph C and C5.
24. Paragraph D and D5.
25. Paragraph E and E5.
26. Paragraph F and F5.

DATE: November 30, 2009
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

Terms of Probation

- 1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).**
- 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. 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.**

- 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 make available for review by OPMC, and/or in OPMC's discretion, by a physician proposed by Respondent and approved, in writing, by the Director of OPMC, complete copies of any and all medical and office records selected by OPMC. Respondent shall fully cooperate in the review process.**
- 8. Respondent shall refrain from ordering, performing and/or interpreting electrodiagnostic nerve and muscle studies from this Determination and Order's effective date and continuing as long as Respondent remains a licensee in New York State.**
- 9. 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.**