



New York State Board for Professional Medical Conduct

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

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
*Commissioner
NYS Department of Health*

Dennis P. Whalen
*Executive Deputy Commissioner
NYS Department of Health*

Dennis J. Graziano, Director
Office of Professional Medical Conduct

Kendrick A. Sears, M.D.
Chairman

Michael A. Gonzalez, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

May 24, 2006

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

David Graham, M.D.
238 North Main Street
Wellsville, NY 14895

Re: License No. 128563

Dear Dr. Graham:

Enclosed is a copy of Order #BPMC 06-120 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect May 31, 2006.

If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to the Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Marylou Roshia, Esq.
Damon & Morey, LLP
100 Cathedral Place
298 Main Street
Buffalo, NY 14202-4096

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

IN THE MATTER
OF
DAVID GRAHAM, M.D.

CONSENT
ORDER

BPMC No. #06-120

Upon the application of (Respondent) DAVID GRAHAM, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 5-24-2006


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

**IN THE MATTER
OF
DAVID GRAHAM, M.D.**

**CONSENT
AGREEMENT
AND
ORDER**

DAVID GRAHAM, M.D., representing that all of the following statements are true, deposes and says:

That on or about September 24, 1976, I was licensed to practice as a physician in the State of New York, and issued License No. 128563 by the New York State Education Department.

My current address is 238 North Main Street, Wellsville, New York 14895, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with thirty-five specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I plead guilty to the thirty-fourth specification as it relates to factual allegations A.2 and C.2, in full satisfaction of the charges against me, and agree to the following penalty:

Pursuant to Public Health Law §230-a (2) (b), my license to practice medicine in the State of New York shall be suspended wholly, effective immediately on the effective date of this Order, except to the limited extent required for the Respondent to complete a course

of clinical competency assessment and retraining, as set forth below. Until I complete such course, which shall be defined as set forth in Exhibit "C", this suspension shall have the force and effect of a suspension of my license, wholly, pursuant to Public Health Law §230- (a) (2).

Pursuant to Public Health Law §230-a (8), Respondent shall be required to complete a course of clinical competency assessment and retraining as more fully set forth in Exhibit "C".

Thereafter, pursuant to N.Y. Pub. Health Law § 230-a(2), my license to practice medicine in New York State shall be suspended for thirty-six (36) months, the term of said suspension to be stayed.

Pursuant to Public Health Law §230-a (9), Respondent shall be placed on probation for a period of three (3) years following the completion of the clinical competency assessment and retraining, set forth above, and subject to the terms set forth in Exhibits "B." Such probation is to begin immediately on the effective date of this Order, and in no event shall terminate sooner than three (3) years after the successful completion of the required clinical competency assessment and retraining program. Leave to request a termination of probation thereafter, and upon successful compliance with all terms of this Order, shall be made to the Director of OPMC, the granting of which petition is within the Director's reasonable discretion.

Pursuant to N.Y. Pub. Health Law § 230-a(3), my license to practice medicine in New York State shall be permanently limited to preclude the prescribing, dispensing or administration of all narcotic agonists and all controlled substances encompassed in Schedules I, II, III, IV and V of New York Public Health Law §3306, and all controlled substances encompassed in Schedules I, II, III, IV and V of 21 U.S.C §812.

I shall further be subject to a condition that I comply with Exhibit "D" "Guidelines For Closing a Medical Practice Following a Revocation, Surrender or Suspension (Of 6 Months or More) of a Medical License," attached hereto.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 30 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional

Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed.

Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in the future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent 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.

DATE May 23, 2006

David H. Graham, M.D.

DAVID GRAHAM, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 5/23/06


MARYLOU ROSHIA, ESQ.
Attorney for Respondent

DATE: 5-23-06


LEE A. DAVIS
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 24 May 2006

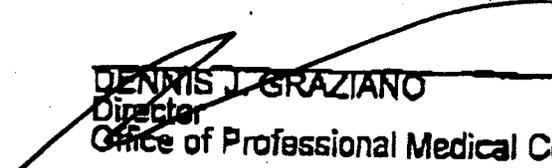

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

**IN THE MATTER
OF
DAVID GRAHAM, M.D.**

**STATEMENT
OF
CHARGES**

DAVID GRAHAM, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 24, 1976, by the issuance of license number 128563 by the New York State Education Department. Respondent is currently registered with the State Education Department through August 31, 2006.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care and treatment as the primary care physician to Patient A (patients are identified in Appendix A, attached hereto), a female patient 28 years old when first treated for back pain, chronic obstructive pulmonary disease, deep vein thrombosis, and depression from on or about July 8, 1999 through on or about November 3, 2005, at his office located at 238 North Main Street, Wellsville, New York. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:
1. Respondent prescribed overlapping and excessive controlled narcotic pain medications without obtaining and/or recording objective findings related to Patient A's pain issues;
 2. Respondent prescribed increased the strength of controlled narcotic pain medications to Patient A while she was displaying dependent and addictive tendencies to the medications;

documenting the impact upon her recurrent pulmonary infections and her chronic smoking;

4. Respondent failed to perform and/or record a physical examination of Patient A's lumbar spine;
5. Respondent failed to ever perform and/or record a physical examination of Patient A;
6. Respondent failed adequately diagnose, treat and/or document the diagnosis and treatment of Patient A's suspected asthma and/or pulmonary disease; and
7. Respondent failed to perform and/or record routine health assessments and health maintenance measures of Patient A.

B. Respondent provided medical care and treatment as the primary care physician to Patient B, a male patient 40 years old when first treated for upper respiratory infections, cervical back pain, hypertension, elevated liver function tests and abdominal pain from on or about February 19, 1991 through on or about November 14, 2005, at his office located at 238 North Main Street, Wellsville, New York. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent regularly prescribed overlapping and excessive refills of controlled narcotic pain medications without obtaining and/or recording objective findings related to Patient B's pain issues from January 23, 2003 through November 14, 2005;
2. Respondent prescribed controlled narcotic analgesics to Patient B when Patient B had elevated liver function tests, noted jaundice and a history of alcohol abuse;
3. Respondent failed to obtain and/or record a Gastroenterology consult for Patient B despite the patient's history of alcohol abuse, elevated liver function tests, noted jaundice and Respondent's prescribing increased dosages of narcotic analgesics;
4. Respondent prescribed Patient B stronger narcotic analgesics after the patient had demonstrated signs of addiction and drug diversion and/or after the pain management consultant elected not prescribe stronger pain medication;

5. Respondent failed to order and/or record a referral to physical therapy and neurosurgery in a timely fashion; and
6. Respondent failed to perform and/or record routine physical assessments and health screenings of Patient B.

C. Respondent provided medical care and treatment as the primary care physician to Patient C, a male patient 24 years old when first treated for low back pain, panic attacks and depression from on or about January 27, 2004 through on or about March 5, 2005, at his office located at 238 North Main Street, Wellsville, New York. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent prescribed overlapping controlled narcotic pain medications without obtaining and/or recording objective findings related to Patient C's pain issues;
2. Respondent failed to refer Patient C to a psychiatrist, pain management specialist or chemical dependency specialist after he exhibited signs of dependence and addiction to the controlled narcotic medication;
3. Respondent prescribed various anxiolytics, antidepressants, muscle relaxants, hypnotics and anti-psychotic medications in combination with narcotic analgesics without benefit of referrals to appropriate consultants;
4. On or about September 10, 2004, Respondent increased the medication Kadian to Patient C without any justification in the record after noting that Respondent had received a notice from the New York State Department of Health regarding his prescribing practices; and
5. Respondent failed to perform and/or record routine physical assessments and screenings of Patient C.

D. Respondent provided medical care and treatment as the primary care physician to Patient D, a male patient 42 years old when first treated for back pain, chronic obstructive pulmonary disease and anxiety from on or about November 28, 1994 through on or about November 29, 2004, at his office located at 238 North Main Street, Wellsville, New York. Respondent's care

and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent prescribed overlapping and excessive controlled narcotic pain medications without obtaining and/or recording objective findings related to Patient D's pain issues;
2. Respondent prescribed controlled narcotic pain medications to Patient D while the patient was displaying characteristics of addiction;
3. Respondent failed to make an appropriate referral of Patient D for evaluation to psychiatrist, pain management specialist or chemical dependency specialist given Patient D's addictive tendencies to the pain medication;
4. Respondent failed to adequately diagnose and/or treat Patient D's Chronic Obstructive Pulmonary Disease; and
5. Respondent failed to perform and/or record routine physical examinations, health assessments and screenings of Patient D.

E. Respondent provided medical care and treatment as the primary care physician to Patient E, a female patient 63 years old when treated for chronic obstructive pulmonary disease, congestive heart failure and diabetes mellitus, from on or about October 30, 2000 through her demise on or about January 17, 2001 at his office located at 238 North Main Street, Wellsville, New York and Jones Memorial Hospital in Wellsville, New York.

Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or record a measure of Patient E's oxygen saturation level at her November 28, 2000 office visit following her October 30 through November 6, 2000 hospitalization, after which she was discharged with a diagnosis of *inter alia*, severe chronic obstructive pulmonary disease and provided with nasal oxygen;
2. Respondent's history and physical examination of patient E was dictated on February 11, 2001, 26 days after Patient E was admitted to Jones Memorial Hospital;
3. Respondent failed to document Patient E's existing medication regimen at the time of her January 16, 2001 admission to Jones

Memorial Hospital in her recorded history and physical examination;

4. Respondent's dictated admission history and physical examination note for Patient's E's January 16, 2001 admission to Jones Memorial Hospital failed to mention the results of her laboratory, radiological or cardiology studies;
5. Respondent failed to develop and/or record a management plan for his treatment of Patient E for her January 16, 2001 admission to Jones Memorial Hospital;
6. Respondent failed to adequately treat and/or record Patient E's documented COPD and hypoxia during her admission to Jones Memorial Hospital;
7. Respondent failed to adequately treat and/or record Patient E's cardiac condition upon her admission to Jones Memorial Hospital on January 16, 2001 with her admitting history and complaints of shortness of breath and chest pains for four days, by not ordering cardiac medications, repeat EKG or troponin levels, given her EKG upon admission which demonstrated widespread subendocardial ischemia;
8. Respondent's ordering of glucophage for Patient E's hyperglycemia during her January 16, 2001 admission to Jones Memorial Hospital was contraindicated, in light of Patient E's documented metabolic derangement and hypoxia; and
9. Respondent inadequately monitored Patient E's fluids and electrolytes during her January 16, 2001 admission to Jones Memorial Hospital given Patient E's hyperglycemia and overall instability.

F. Respondent provided medical care and treatment as the primary care physician to Patient F, a female patient 81 years old when treated for respiratory distress, chronic obstructive pulmonary disease and congestive heart failure from on or about March 18, 2002 through her demise on or about March 19, 2002 at Jones Memorial Hospital in Wellsville, New York. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record a history and physical examination for Patient F upon her March 18, 2002 admission to Jones Memorial Hospital;

2. Respondent failed to record an admission note for Patient F's March 18, 2002 admission to Jones Memorial Hospital;
3. Respondent failed to develop and/or record a management plan for his treatment of Patient F for her March 18, 2002 admission to Jones Memorial Hospital;
4. Respondent failed to record a progress note for patient F's March 18, 2002 admission to Jones Memorial Hospital;
5. Respondent failed to adequately manage and/or record Patient F's hyperkalemia during her March 18, 2002 admission to Jones Memorial Hospital;
6. Respondent failed to adequately manage and/or record Patient F's hyperglycemia during her March 18, 2002 admission to Jones Memorial Hospital;
7. Respondent failed to adequately manage and/or record Patient F's chronic obstructive pulmonary disease during her March 18, 2002 admission to Jones Memorial Hospital;
8. Respondent failed to record the episode of respiratory arrest or resuscitation that caused him to obtain a consult for Patient F; and
9. Respondent failed to order and/or record a timely consult following Patient F's respiratory arrest and intubation.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

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

1. A. and A.2;
2. A. and A.3;
3. B. and B.2;
4. B. and B.3;
5. C. and C.2;
6. C. and C.3;
7. C. and C.4;
8. D. and D.2;
9. D. and D.3;
10. D. and D.4;
11. E. and E.5;
12. E. and E.6;
13. E. and E.7;
14. F. and F.5;
15. F. and F.6; and/or
16. F. and F.9.

SEVENTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

17. A. and A.2, A. and A.3, B. and B.2, B. and B.3, B. and B.4, C. and C.2, C. and C.3, C. and C.4., D. and D.2, D. and D.3, D. and D.4, E. and E.5, E. and E.6, E. and E.7, F. and F.5, F. and F.6, and/or F. and F.9.

EIGHTEENTH THROUGH THIRTY-THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

18. A. and A.2;
19. A. and A.3;
20. B. and B.2;
21. B. and B.3;
22. C. and C.2;
23. C. and C.3;
24. C. and C.4;
25. D. and D.2;
26. D. and D.3;
27. D. and D.4;
28. E. and E.5;
29. E. and E.6;

- 30. E. and E.7;
- 31. F. and F.5;
- 32. F. and F.6; and/or
- 33. F. and F.9.

THIRTY-FOURTH 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:

- 34. A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, A. and A.7, B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, C. and C.1, C. and C.2, C. and C.3, C. and C.4, C. and C.5, D. and D.1, D. and D.2, D. and D.3, D. and D.4, D. and D.5, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, E. and E.6, E. and E.7, E. and E.8, E. and E.9, F. and F.1, F. and F.2, F. and F.3, F. and F.4, F. and F.5, F. and F.6, F. and F.7, F. and F.8 and/or F. and F.9.

THIRTY-FIFTH SPECIFICATION
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:

- 35. A. and A.1, A. and A.4, A. and A.5, A. and A.6, A. and A.7, B. and B.1, B. and B.3, B. and B.5, B. and B.6, C. and C.1, C. and C.5, D. and D.1, D. and D.5, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, E. and E.6, F. and F.1, F. and F.2, F. and F.3, F. and F.4, F. and F.5, F. and F.6, E. and E.7, F. and F.7, F. and F.8, and/or F. and F.9.

DATE: May 15, 2006
Albany, New York


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

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).
2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.
3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.
4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.
5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].
6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.
8. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

CONTINUING MEDICAL EDUCATION

9. Subject to the Director of OPMC's prior written approval:
 - a. Respondent shall enroll in and complete a continuing education program in the area of medical record keeping, to be completed within the first year of the probation period.
 - b. Respondent shall enroll in and complete a continuing education program in the area of diagnoses and treatment of acute and chronic conditions in the elderly, for a minimum of 50 credit hours per year during the period of probation.

PRACTICE MONITOR

10. Upon commencement of probation, unless otherwise directed, 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.
 - 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 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.
 - 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 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.

PRACTICE SUPERVISOR

11. Upon OPMC review of the clinical competency assessment report and retraining recommendations as set forth in Exhibit "C" herein, the Director may render a decision, at said Director's sole discretion, that Respondent's practice of medicine shall be subject to a practice supervisor. If so directed, Respondent shall practice medicine only when supervised in his medical practice. The practice supervisor shall be on-site at all locations, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.
 - a. Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess Respondent's medical practice. Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.
 - b. Respondent shall authorize the practice supervisor to have access to his patient records and to submit quarterly written reports to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review and other such on-duty conduct as the supervisor deems appropriate to report.
12. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

EXHIBIT "C"

CLINICAL COMPETENCY ASSESSMENT

1. Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC.
2. Within thirty (30) days of receipt of the clinical competency assessment report by OPMC, the Director may direct that Respondent be enrolled in a course of personalized continuing medical education, which includes an assigned preceptor, preferably a physician board certified in the same specialty, to be approved, in writing, by the Director of OPMC. Respondent shall cause the preceptor to:
 - a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a time frame for completion of the remediation program.
 - b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.
 - c. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.
 - d. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.
3. Additionally, the Director shall determine such other terms and/or condition of practice, if any, as may be consistent with the recommendation(s) in the clinical competency assessment report.
4. Respondent shall be responsible for all expenses related to the clinical competency assessment and retraining and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This term shall not be satisfied in the absence of actual receipt, by the Director, of such documentation, and any failure to satisfy shall provide a basis for a Violation of Probation proceeding.

EXHIBIT "D"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE FOLLOWING A REVOCATION, SURRENDER OR SUSPENSION (of 6 months or more) OF A MEDICAL LICENSE

1. Respondent shall immediately cease the practice of medicine in compliance with the terms of the Consent Order. Respondent shall not represent himself or herself as eligible to practice medicine and shall refrain from providing an opinion as to professional practice or its application.
2. Within 15 days of the Consent Order's effective date, Respondent shall notify all patients that he or she has ceased the practice of medicine, and shall refer all patients to another licensed practicing physician for their continued care, as appropriate.
3. Within 30 days of the Consent Order's effective date, Respondent shall have his or her original license to practice medicine in New York State and current biennial registration delivered to the Office of Professional Medical Conduct (OPMC) at 433 River Street Suite 303, Troy, NY 12180-2299.
4. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within 30 days of the Consent Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate contact person, acceptable to the Director of OPMC, who shall have access to these records. Original records shall be retained for patients for at least 6 years after the last date of service, and, for minors, at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall ensure that all patient information is kept confidential and is available only to authorized persons. When a patient or authorized representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or sent at reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of inability to pay.
5. Within 15 days of the Consent Order's effective date, if Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall advise the DEA in writing of the licensure action and shall surrender his or her DEA controlled substance certificate, privileges, and any used DEA #222 U.S. Official Order Forms Schedules 1 and 2, to the DEA.
6. Within 15 days of the Consent Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Respondent shall have all prescription pads bearing Respondent's name destroyed. If no other licensee is providing services at Respondent's practice location, Respondent shall dispose of all medications.

7. Within 15 days of the Consent Order's effective date, Respondent shall remove from the public domain any representation that Respondent is eligible to practice medicine, including all related signs, advertisements, professional listings whether in telephone directories or otherwise, professional stationery or billings. Respondent shall not share, occupy or use office space in which another licensee provides health care services.
8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered (by himself or others) while barred from practicing medicine. Respondent may receive compensation for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Consent Order's effective date.
9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and Respondent's license is revoked, surrendered or suspended for 6 months or more pursuant to this Consent Order, Respondent shall, within 90 days of the Consent Order's effective date, divest himself/herself of all financial interest in such professional services corporation in accordance with N.Y. Bus. Corp. Law. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Consent Order's effective date.
10. Failure to comply with the above directives may result in civil or criminal penalties. Practicing medicine when a medical license has been suspended, revoked or annulled is a Class E Felony, punishable by imprisonment for up to four years, under N.Y. Educ. Law § 6512. Professional misconduct may result in penalties including revocation of the suspended license and/or fines of up to \$10,000 for each specification of misconduct, under N.Y. Pub. Health Law § 230-a.