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HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2013

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey J. Conklin, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Mark R. Affronti, Esq.
Roach, Brown, McCarthy & Gruber, P.C.
424 Main Street
Buffalo, New York 14202

Dham Gupta, M.D.
REDACTED

RE: In the Matter of Dham Gupta, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 13-201) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

REDACTED

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
OF	:	AND
DHAM GUPTA, M.D.	:	ORDER
		BPMC #13-201

A Notice of Hearing and Statement of Charges, dated September 25, 2012, were served upon the Respondent, Dham Gupta, M.D. **LYON M. GREENBERG, M.D., (Chair), RICHARD EDMONDS, Ph.D., and WILLIAM A. TEDESCO, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Jeffrey J. Conklin, Esq.; Associate Counsel. The Respondent appeared by Roach, Brown, McCarthy & Gruber, P.C., Mark R. Affronti, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	October 2, 2012
Answer Filed:	October 19, 2012
Pre-Hearing Conference:	October 22, 2012
Hearing Dates:	December 7, 2012 January 11, 2013 January 18, 2013
Witnesses for Petitioner:	Carol Janicki, R.N. Harvey M. Berman, M.D.
Witnesses for Respondent:	Dham Gupta, M.D.
Deliberations Held:	February 28, 2013

STATEMENT OF CASE

Petitioner has charged Respondent, a psychiatrist, with fourteen specifications of professional misconduct. The charges relate to the care and treatment rendered to five patients. The charges include allegations of gross negligence, in violation of N.Y. Education Law §6530(4); gross incompetence, in violation of N.Y. Education Law §6530(6); negligence on more than one occasion, in violation of N.Y. Education Law §6530(3); incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5); failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32), and

engaging in conduct evidencing moral unfitness to practice the profession, in violation of N.Y. Education Law §6530(20).

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

Respondent filed an Answer to the Statement of Charges denying all factual allegations and specifications of professional misconduct.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

Respondent

1. Dham Gupta, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 153750 on or about April 8, 1983. (Exhibit #3).

Patient A

2. Respondent provided psychiatric care to Patient A, a 49 year old female, at the Niagara County Department of Mental Health (hereinafter "NCDMH"), Niagara Falls, New York, from January 13, 2010 through September 20, 2010. (Exhibit #5, pp. 4, 20-33).

3. Patient A had a history of delusional disorder, paranoid personality disorder and substance abuse, including crack cocaine and alcohol. (Exhibit #5, p. 33; T, pp. 89, 91, 325).

4. Respondent, who was a psychiatric consultant with NCDMH, saw Patient A on January 13, April 7, July 1 and September 20, 2010. (Exhibit #5, p. 4; T., pp. 20, 92).

5. Patient A's presenting problems included paranoia, depression, anxiety, and suicidal and homicidal thoughts, in the context of an ongoing abusive and violent domestic relationship. (Exhibit #5, pp., 28-29, 49; T. pp. 90-91, 328).

6. Patient A had a long history of admissions to Memorial Hospital for her psychiatric condition, with a history of several suicide attempts by drug overdose. (Exhibit #5, p. 33; T., p. 327).

7. Respondent performed an initial psychiatric examination of Patient A on January 13, 2010, and diagnosed her with delusional disorder persecutory type, polysubstance abuse and dependence in remission, paranoid personality disorder, blindness in the left eye, diabetes, hypertension and arthritis. (Exhibit #5, pp. 33-34; T. p. 92).

8. During an office visit to the NCDMH, Respondent requested assistance from Patient A in recruiting a white girl for sex. Respondent admitted that this conversation took place during a treatment session with Patient A. (T. pp. 33-34, 340).

9. Respondent admitted that money was not a concern and that he could spend any amount of money. (T. pp. 34, 321).

10. Respondent admitted that the money was for Patient A. (T. p. 35).

11. Respondent admitted that he contacted Patient A about the status of his request, and that he called her to follow-up on his request. (T. p. 35).

12. Respondent chose Patient A to recruit a girlfriend because she was outgoing and talkative. (T. p. 36).

13. The standard of care for treating Patient A required that Respondent provide psychotherapy, medication

management, and to maintain appropriate professional boundaries with Patient A so as to avoid contaminating the doctor-patient relationship with outside influences that could undermine the treatment. (T. p. 95).

14. On December 9, 2010, Patient A advised Juliana Plune, a licensed social worker with NCDMH that she had concerns about the psychiatrist she had been seeing, and gave that as a reason that she did not go to her last appointments. Ms. Plune advised Carol Ross, director of clinics at NCDMH regarding Patient A's concerns. (Exhibit #5, p. 5; T. p. 116).

15. Respondent admitted that his conversation with Patient A could have affected her adversely. (T. p. 36).

16. The standard of care for preparing and maintaining psychiatric records required the adequate documentation of findings during every contact with the patient, including office visits, telephone contacts and other conversations. This would include documenting any conversation between doctor and patient about matters other than the psychiatric care and treatment already in the records. (T. p.98).

17. Respondent's medical record for Patient A did not document his solicitation of Patient A in finding a girlfriend. (T. pp. 98-99).

Patient B

18. Respondent provided psychiatric care to Patient B, a 53 year old male, at NCDMH from July 8, 2010, through on or about September, 2010. (Exhibit #4A).

19. Patient B presented with a history of major depression, anxiety disorder and substance abuse, including opiates and alcohol. (Exhibit #4A, p. 15; T. pp. 118-119).

20. Respondent saw Patient B on July 22, 2010. (Exhibit #4A, p. 15; T. pp., 118-119, 342-343).

21. Patient B's presenting problems on that date were depression, anxiety, chemical dependency, and feeling hopeless, helpless and suicidal. (Exhibit #4A, p. 15; T., pp. 118-119).

22. Patient B had a long history of hospitalizations for recurrent depression and suicidal thoughts. In 2002, 2003, and October 2006, Patient B attempted suicide by heroin overdose. (Exhibit #4A, p. 15; Exhibit #4B,pp. 24,64; T. pp. 92,133,136).

23. Patient B had been admitted to detox facilities 15 times over a 25 year period of time, mainly for addiction to heroin. (Exhibit #4A, p. 20; T. pp. 119-20).

24. Respondent performed an initial psychiatric examination of Patient B on July 22, 2010. He diagnosed the patient as having major depression recurrent, anxiety disorder, opiate dependence, polysubstance abuse, hypertension, non-insulin dependent diabetes, and HIV. (Exhibit #4A, pp. 15; T. pp. 120, 243, 344).

25. During an office visit to the NCDMH on July 22, 2010,Respondent requested assistance from Patient B in recruiting a white girl, age 20 to 27, with no drug problems, for monetary compensation. (Exhibit #4B, pp. 86-87; Exhibit #9B; T. pp. 21-22, 32, 123-124. 136, 138).

26. Respondent admitted that money was not a concern. (T. p. 21-22, 24, 344).

27. Respondent admitted that he contacted Patient B about the status of this request, and that he called him on several occasions to follow-up on the conversation. Respondent also admitted calling Patient B on two to three occasions, and that he gave the patient his pager number. (T. pp. 26-31, 345).

28. Telephone logs confirmed that calls were made to Patient B's cell phone on July 26, 2010, and August 19, 2010 when Respondent was using the clinic's doctors' office. (Exhibit #9G, p. 1).

29. Respondent admitted choosing Patient B to recruit a girlfriend because he was outgoing and talkative. (T. p.36).

30. The standard of care for treating Patient B required avoiding any contamination of the doctor-patient relationship with outside influences, which could undermine the treatment. (T. pp. 95, 126).

31. Respondent's failure to document his conversations with Respondent about recruiting women breached the standard of care for record-keeping. (T. pp. 98, 113).

32. On August 19, 2010, Patient B was admitted to the Brylin Hospital, with a diagnosis of major recurrent depression and polysubstance abuse. Prior to this admission, Patient B relapsed on heroin. (T. pp.132-134; Exhibit #4B).

33. Patient B's presenting problems were depression, inability to sleep, loss of appetite, feeling hopeless and helpless, and experiencing suicidal thoughts. (T. pp. 133-134; Exhibit #4B, p 24).

34. Patient B was seen by a psychiatrist on August 21, 2010 and reported that he "...want[ed] to discuss his concerns with his outpatient psychiatrist who was trying to bribe him with drugs and money in order to get girlfriends." (T. p. 136; Exhibit #4B, p. 86).

Patient C

35. Patient C, a 53 year old female, presented to the Niagara County Department of Mental Health on September 28, 2009, with complaints of severe depression, difficulty sleeping, feeling anxious, lack of energy, guilt feelings, and heart racing. (T. p. 268; Exhibit #8, p. 54).

36. Patient C had a history of major depression and alcoholism. (T. p. 267; Exhibit #8, p. 54).

37. Respondent was Patient C's consulting psychiatrist, and diagnosed the patient with adjustment disorder with mixed emotional features, depressive disorder, not otherwise specified, alcohol dependence and cannabis abuse. (T. p. 268; Exhibit #8, p. 55).

Patient D

38. Respondent provided psychiatric care for Patient D, a 23 year old male, at the Buffalo Psychiatric Center from on or about August, 2005 through July, 2006. (Exhibit #6).

39. Patient D had a history of schizophrenia, auditory hallucinations, persecutory delusions, suicidal ideation, and suicide attempts. (T. pp. 170-171' Exhibit #6, p. 58).

40. At the time of Patient D's admission to the Buffalo Psychiatric Center, Respondent prescribed Seroquel and Prolixin to reduce and control hallucinations and paranoid thinking, Trazodone and Lexapro to reduce depression, suicidal and self-harmful behaviors, and Klonopin to reduce anxiousness. (T. p. 172; Exhibit #6, p. 59).

41. As part of his treatment plan, Respondent was to meet with Patient D twice per week, or as needed, to evaluate his mental status and to monitor any changes, assessing the effects of medications, psychosocial treatments and war/hospital milieu. (T. pp. 172-173; Exhibit #6, p. 59).

42. In May, 2006, Respondent's diagnoses of Patient D's condition included schizoaffective disorder, depressed type, borderline personality disorder, and polysubstance abuse. (Exhibit #6, p. 63).

43. Patient D was severely and acutely ill. He was psychotic and prone to engage in bizarre and inappropriate behaviors. (T. pp. 170-171).

44. On June 9 and June 22, 2006, Respondent ordered day passes for Patient D to visit his family on Saturdays and Sundays from 12:00 p.m. to 9:00 p.m. (T. p. 174; Exhibit #6, p. 24).

45. Patient D visited his family on day passes ordered by Respondent on June 11, June 18, June 25, and July 9, 2006. (Exhibit #6, pp. 99, 100, 105, 106, 109, 110, 12 and 123).

46. On July 9, 2006, Patient D attempted suicide by lacerating his wrists and cutting his face while on home leave ordered by Respondent. (T. pp. 178-179; Exhibit #6, p. 125).

Patient E

47. Patient E, a 58 year old female, was admitted to the St. Joseph's Medical Center on July 17, 2006, upon being transferred from the Vivian Teal Nursing Home. (T. pp. 227-228; Exhibit #7, p. 410).

48. Patient E had a complicated medical and psychiatric history, which included a multiple personality disorder. (T. p. 228; Exhibit #7, p. 410).

49. At the time of her admission, Patient E was experiencing a new personality, Janita, who was telling her to be violent towards herself. (T. p. 228; Exhibit #7, p. 410).

50. Respondent was the examining physician for Patient E at the facility. (Exhibit #7, p. 410).

51. Respondent indicated that Patient E was acutely psychotic, paranoid and delusional. She was not taking her medications and was suicidal. (T. p. 231; Exhibit #7, p. 388).

52. On July 21, 2006 at approximately 1500 hours, Patient E was found by staff with a sheet tied around her neck. She also used a pillowcase and hospital gown in an attempt to commit suicide. (T. p. 232; Exhibit #7, p. 158).

53. Patient E hit and kicked staff members as they held her down. She began gouging at her eyes and pulling her hair out. (T. p. 232; Exhibit #7, p. 158).

54. Patient E was placed in four point restraints. Upon being released from the restraints at approximately 1745 hours, she again attempted to harm herself and staff members. (T. pp. 232-233; Exhibit #7, p. 89).

55. On July 21, 2006, at the time of this incident, Respondent was responsible for covering the hospital's Comprehensive Psychiatric Emergency Program ("CPEP"), as well as the In-Patient Psychiatric Unit as the on-call psychiatrist. (T. pp. 41-42, 234).

56. The In-Patient Unit staff contacted Respondent to perform an evaluation of Patient E, seeking a renewal of the restraint order. (T. pp. 42, 234, 416-417).

57. At the time of the phone call, Respondent was the only physician staffing the CPEP, and there were 20-25 patients awaiting treatment, many of them children. Respondent was unable to leave the CPEP to evaluate Patient E. The staff then contacted Patient E's attending psychiatrist, who authorized the use of restraints. (T. pp. 411-414, 417; Exhibit #7, p. 58).

CONCLUSIONS OF LAW

Respondent is charged with fourteen specifications of professional misconduct. The charges relate to the care and treatment rendered to five patients. Respondent is charged with gross negligence, in violation of N.Y. Education Law §6530(4); gross incompetence, in violation of N.Y. Education Law §6530(6); negligence on more than one occasion, in violation of N.Y. Education Law §6530(3); incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5); engaging in conduct in the practice of the profession that evidences moral unfitness to practice, in violation of N.Y. Education Law §6530(20), and failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32).

The Education Law sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation

from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Respondent has also been charged with engaging in conduct which evidences moral unfitness to practice the profession. To sustain an allegation of moral unfitness, the Department must show that Respondent committed acts which "evidence moral unfitness". There is a distinction between finding that an act evidences moral unfitness, and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Hearing Committee is asked to decide if certain

conduct is suggestive of, or would tend to prove, moral unfitness. The Committee is not called on to make an overall judgment regarding a Respondent's moral character. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

The standard for moral unfitness in the practice of medicine is twofold. First, there may be a finding that the accused has violated the public trust which is bestowed by virtue of his licensure as a physician. Physicians have privileges that are available solely due to the fact that one is a physician. For instance, physicians have access to controlled substances and billing privileges that are available only to licensed physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Therefore, it is expected that a physician will not violate the trust the public has bestowed upon him or her by virtue of their professional status.

Second, moral unfitness can be seen as a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent. Miller v. Commissioner of Health, 270 A.D.2d 584, 703 N.Y.S.2d

830 (3rd. Dept. 2000); Selkin v. State Board for Professional Medical Conduct, 279 A.D.2d 720, 719 N.Y.S.2d 195 (3rd Dept.) *appeal denied* 96 N.Y.2d 928, 733 N.Y.S.2d 363 (2001); Barad v. State Board for Professional Medical Conduct, 282 A.D.2d 893, 724 N.Y.S.2d 488 (3rd Dept. 2001); Reddy v. State Board for Professional Medical Conduct, 259 A.D.2d 847, 686 N.Y.S.2d 520 (3rd Dept.) *leave denied* 93 N.Y.2d 813, 695 N.Y.S.2d 541 (1999).

For the remaining specifications of misconduct the Hearing Committee interpreted the statute in light of the usual and commonly understood meaning of the underlying language. (*See*, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first evaluated the credibility of the witnesses presented by the parties. The Department presented two witnesses. The first was Carol Janicki, R.N. Ms. Janicki is an investigator employed by the Office of Professional Medical Conduct. She testified regarding her interview of Respondent, and various statements that he made to

her during the course of that interview. The Committee found Ms. Janicki to be a very credible witness.

The Department also presented Harvey M. Berman, M.D. Dr. Berman is a board-certified psychiatrist, and a clinical associate professor of psychiatry at New York Medical College. (Exhibit #18). Dr. Berman's testimony was somewhat problematic. Although he was very direct in his responses on direct examination, he grew increasingly defensive and equivocal under cross-examination. The Committee found Dr. Berman credible on the issue of inappropriate behaviors toward patients, and general record-keeping requirements. He was found less credible on other matters.

Dr. Gupta presented no witnesses, but testified on his own behalf. Given his obvious interest in the outcome of the case, the Committee gave his testimony close scrutiny. The Committee found several aspects of his testimony troubling. Respondent was very evasive on cross-examination and questioning by the Committee. He admitted enlisting Patients A and B for obtaining sex partners, yet claimed it was all in jest. Nevertheless, the recorded voicemail left for Patient B demonstrated otherwise. The Committee found Respondent to be an untrustworthy witness.

Patients A and B

Respondent never denied asking Patients A and B to locate "girlfriends" for him. He attempted to claim that it was only in jest, and that he knew that it was inappropriate. He admitted that the conversations took place, but argued that they were taken out of proportion. However, the record proves otherwise. In both cases, Respondent went so far as to telephone the patient to follow-up on his requests. The Hearing Committee concluded that Respondent was not joking, and was in fact, serious when he requested the assistance of his patients in obtaining sex partners. This behavior is intolerable in a physician entrusted with the care of our most vulnerable patients. Both Patient A and Patient B had long psychiatric histories, including drug dependence and suicide attempts, and were in precarious conditions.

Respondent clearly did not document those portions of his treatment sessions with Patients A and B. These requests for sex partners, are certainly relevant for follow-up care with these patients, and their absence is a further deviation from accepted standards of practice.

The Hearing Committee concluded that Respondent's conduct with regard to Patients A and B demonstrated an especially egregious deviation from the standard of care, rising

to the level of gross negligence. As a result, the Committee voted to sustain the First and Second Specifications of professional misconduct set forth in the Statement of Charges. The Committee found no evidence of incompetence on Respondent's part. He recognized that his conduct was inappropriate, but went ahead anyway. Therefore the Committee dismissed the Sixth and Seventh Specifications.

Respondent's conduct clearly was a breach of the trust granted by society to those who are granted the privilege of a license to practice medicine. By using his position of trust to coax vulnerable patients into helping him find sexual partners, Respondent clearly demonstrated conduct evidencing moral unfitness to practice the profession of medicine. As a result, the Hearing Committee further sustained the Eleventh and Twelfth Specifications of professional misconduct.

Lastly, by failing to document his conversations with Patients A and B, Respondent failed to accurately document his complete evaluation and treatment of these patients. Accordingly, the Committee voted to sustain the Fourteenth Specification.

Patient C

The allegations against Respondent are somewhat similar to those raised concerning Patients A and B. He is

alleged to have engaged in an inappropriate conversation with the patient about getting a girlfriend. In this case, however, Respondent never admitted that the discussion occurred. Given the lack of that admission, it was necessary for the Department to present the patient for testimony. The Department did not do so, on the ground that she was too fragile to testify. That may be so, but in the absence of that testimony, there is insufficient evidence to sustain the allegations against Respondent. Therefore, the Committee voted to dismiss the Fifth, Tenth, and Fourteenth Specifications as applied to Patient C, as well as the Thirteenth Specification.

Patient D

The Department alleged that Respondent failed to appropriately reevaluate Patient D's condition, when requested by hospital staff; failed to appropriately change the patient's pass orders when indicated; failed to appropriately document the rationale for issuing pass orders; failing to provide appropriate psychiatric care to the patient; failed to appropriately evaluate Patient D prior to his suicide attempt on July 9, 2007, and failed to maintain appropriate records. The Hearing Committee, upon consideration of the record, concluded that none of the factual allegations had been sustained.

Patient D was a 22 year old male with a history of psychiatric disease, who had been in and out of mental health facilities. He was admitted to the Buffalo Psychiatric Center in 2005. In 2006, Respondent was his attending psychiatrist. In April, 2006, Respondent determined that it was appropriate to allow the patient to leave the facility on day passes, under his parents' supervision. During a home visit on July 9, 2006, Patient D attempted suicide.

The Department alleged that Respondent failed to reevaluate Patient D when it was requested by hospital staff. There is no evidence in the record that such a request was ever made. Therefore this factual allegation must be dismissed.

Similarly, there is no evidence in the record, including Dr. Berman's testimony that Respondent failed to appropriately change the patient's pass orders. (See, T. 280, 311). Therefore, this factual allegation was dismissed. The remaining factual allegations were also not supported by either the medical record, or the testimony of the Department's witnesses. Accordingly, all of the factual allegations regarding Patient D were dismissed. As a result, the Hearing Committee dismissed the Third, and Eighth specifications in their entirety, and the Fifth and Fourteenth Specifications as they refer to Patient D.

Patient E

The basic facts in this instance are not in dispute. Patient E was admitted to the In-Patient Psychiatric Unit at St. Joseph's Medical Center. Respondent's evaluation documented that the patient was acutely psychotic, paranoid, delusional, and suicidal. On the date in question, July 17, 2006, Respondent was responsible for covering the hospital's Comprehensive Psychiatric Emergency Program, as well as serving as on-call psychiatrist for the in-patient unit.

When the in-patient unit called to Respondent to evaluate the patient for purposes of renewing an order for restraints, Respondent refused. He testified that he could not leave the CPEP because it was filled with acutely ill patients, mostly children, and he did not feel it was safe to leave them. He noted that the staff could contact Patient E's attending psychiatrist to get the order renewed, and that this in fact occurred.

The Respondent needed to balance competing interests in determining which patients to attend first. This required an exercise of his best professional judgment. Under the circumstances, the Hearing Committee concluded that he properly decided to remain with the patients in the CPEP. As a result, the Committee voted to dismiss all specifications relating to

Patient E, including the Fourth and Ninth Specifications, as well as the Fifth, Tenth Specifications, as they relate to Patient E.

Negligence on More Than One Occasion

The Fifth Specification charges Respondent with practicing with negligence on more than one occasion. Given the fact that the Committee has found Respondent guilty of gross negligence with regard to Patient A and Patient B, it therefore follows that he is also guilty of negligence on more than one occasion. Therefore, the Fifth Specification is sustained with respect to those two patients, but not the remaining three patients.

Incompetence on More Than One Occasion

The Hearing Committee found no evidence of incompetence on Respondent's part. His actions were not based upon a lack of knowledge of what was proper. Therefore, the Committee voted to dismiss the Tenth Specification in its entirety.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's license to practice medicine should be suspended for a period of twelve months. Following the period of

suspension, Respondent shall be placed on probation for a period of five years. Respondent shall also be required to comply with terms and conditions more fully set forth in the Terms of Probation, which are attached to this Determination and Order in Appendix II, and incorporated herein. Respondent shall not commence practice under the terms of probation until he demonstrates to the satisfaction of the Director of the Office of Professional Medical Conduct that he has obtained a psychiatric evaluation, and is compliant with all treatment recommendations. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee gave serious consideration to revoking the Respondent's medical license. Respondent's attempt to enlist his patients' help in obtaining sex partners was a gross deviation from the professional and ethical standards expected from a psychiatrist. He callously manipulated two extremely vulnerable patients, for his benefit, and to their detriment. Had there been any sexual contact between the Respondent and either Patients A or B, the Committee would have voted unanimously to revoke. However, his actions nevertheless

represent a serious breach of the proper boundaries which should always be maintained between psychiatrist and patient.

While not reaching the level of revocation, the Committee is convinced that a serious and significant sanction must be imposed in consequence of Respondent's actions. A full twelve months of actual suspension shall be imposed, followed by five years of probation. In addition, Respondent shall be required to take continuing medical education courses, acceptable to the Director of the Office of Professional Medical Conduct, in the areas of medical ethics and record-keeping. Respondent shall not resume his medical practice until he successfully completes these courses.

Respondent's statements to the contrary notwithstanding, the Committee is of the unanimous opinion that he is suffering from some underlying pathology which led to his aberrant behavior. As a result, the Committee determined that before Respondent resumes his medical practice, he must demonstrate that he has undergone a thorough psychiatric evaluation, and is fully compliant with all treatment recommendations.

ORDER

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

1. The First, Second, Fifth, Eleventh, Twelfth and Fourteenth Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED**;

2. The Third, Fourth, Sixth through Tenth, and Thirteenth Specifications of professional misconduct are **DISMISSED**;

3. Respondent's license to practice medicine in the State of New York shall be **SUSPENDED** for a period of twelve (12) months. Respondent shall thereafter be placed on **PROBATION** for a period of five (5) years. Included in the terms of probation shall be a requirement that Respondent undergo a psychiatric evaluation by a psychiatrist acceptable to the Director of the Office of Professional Medical Conduct, and demonstrate compliance with all treatment recommendations before resuming practice. The complete Terms of Probation are attached to this Determination and Order in Appendix II and incorporated herein.

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by

certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
June 24th, 2013

REDACTED

LYON M. GREENBERG, M.D. (CHAIR)

RICHARD EDMONDS, Ph.D.
WILLIAM A. TEDESCO, M.D.

TO: Jeffrey J. Conklin, Esq.
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Dham Gupta, M.D.
REDACTED

APPENDIX I

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

IN THE MATTER OF DHAM GUPTA, M.D.	STATEMENT OF CHARGES

DHAM GUPTA, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 8, 1983, by the issuance of license number 153750 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric care to Patient A (hereinafter identified in Appendix "A") at the Niagara County Department of Mental Health, Lockport, New York, on or about January through December 2010, as part of her treatment for a psychiatric condition, including delusional disorder, paranoid personality disorder and substance abuse. During such treatment, the Respondent solicited the assistance from Patient A in recruiting women to be sexual partners for said Respondent in exchange for monetary compensation. Respondent had inappropriate communications with Patient A regarding said solicitations. Respondent's psychiatric care of Patient A deviated from accepted standards of care as follows:

1. On multiple occasions, Respondent inappropriately solicited assistance from Patient A to recruit women to be sexual partners for said Respondent;

2. Respondent inappropriately sought to utilize Patient A's home to have sexual relations with women Patient A was requested to recruit for said Respondent;
3. Respondent inappropriately offered Patient A monetary compensation in exchange for Patient A recruiting women to be sexual partners and providing her home for sexual relations with such women for said Respondent;
4. Respondent inappropriately communicated with Patient A to follow-up on Respondent's solicitations of assistance from Patient A to recruit women to be sexual partners for said Respondent;
5. Respondent failed to provide appropriate psychiatric care for Patient A;
6. Respondent's inappropriate solicitations of Patient A to recruit women to be sexual partners for said Respondent in exchange for monetary compensation exacerbated Patient A's psychiatric condition; and
7. Respondent failed to maintain appropriate psychiatric records for Patient A.

B. Respondent provided psychiatric care to Patient B (hereinafter identified in Appendix "A") at the Niagara County Department of Mental Health on or about July through August 2010, as part of his treatment for a psychiatric condition, including depression, anxiety and chemical dependency. During such treatment, the Respondent solicited assistance from Patient B in recruiting women for said Respondent in exchange for monetary compensation. Respondent had inappropriate communications with Patient B regarding said solicitation. Respondent's psychiatric care of Patient B deviated from accepted standards of care as follows:

1. Respondent inappropriately solicited assistance from Patient B to recruit women for said Respondent;
2. Respondent inappropriately offered Patient B monetary compensation in exchange for Patient B recruiting women for said Respondent;
3. On multiple occasions, Respondent inappropriately communicated with Patient B to follow-up on Respondent's solicitation of assistance from Patient B to recruit women for said Respondent;
4. Respondent failed to provide appropriate psychiatric care for Patient B;
5. Respondent's inappropriate solicitation of Patient B for assistance in recruiting women in exchange for monetary compensation and drugs exacerbated Patient B's psychiatric condition; and
6. Respondent failed to maintain appropriate psychiatric records for Patient B.

C. Respondent provided psychiatric care to Patient C (hereinafter identified in Appendix "A") at the Niagara County Department of Mental Health on or about September 2009, as part of her treatment for a psychiatric condition, including depression and alcoholism. During such treatment, the Respondent made inappropriate personal comments to Patient C. Respondent's psychiatric care of Patient C deviated from accepted standards of care as follows:

1. Respondent made inappropriate personal comments to Patient C;
2. Respondent failed to provide appropriate psychiatric care for Patient C; and
3. Respondent failed to maintain appropriate psychiatric records for Patient C.

D. Respondent provided psychiatric care to Patient D (hereinafter identified in Appendix "A") at the Buffalo Psychiatric Center, Buffalo, New York, on or about June 2006, as part of his treatment for a psychiatric condition, including schizophrenia. After Patient D had been granted passes from the Buffalo Psychiatric Center, said patient's condition deteriorated. Respondent's psychiatric care of Patient D deviated from accepted standards of care as follows:

1. Respondent failed to appropriately reevaluate Patient D's psychiatric condition when such reevaluation was requested by staff of the Buffalo Psychiatric Center;
2. Respondent failed to appropriately change Patient D's pass orders from the Buffalo Psychiatric Center when indicated;
3. Respondent failed to appropriately document the rationale for ordering Patient D's passes from the Buffalo Psychiatric Center;
4. Respondent failed to provide appropriate psychiatric care for Patient D;
5. Respondent failed to appropriately reevaluate Patient D as indicated prior to said patient's suicide attempt on July 9, 2006; and
6. Respondent failed to maintain appropriate psychiatric records for Patient D.

E. Respondent provided psychiatric care to patients (hereinafter identified in Appendix "A") at St. Joseph's Medical Center, Syracuse, New York, on July 21, 2006. Patient E was being treated at such facility for a psychiatric condition, including multiple personality disorder. Respondent's psychiatric care of Patient E deviated from accepted standards of care as follows:

1. Respondent inappropriately refused to evaluate Patient E when requested by staff at St. Joseph's Medical Center, as was required of said Respondent as an on-call psychiatrist for in-patients including Patient E, at said facility.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

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

1. The facts of A and A1, A and A2, A and A3, A and A4, A and A5, and A and A6;
2. The facts of B and B1, B and B2, B and B3, B and B4, and B and B5;
3. The facts of D and D1, D and D2, D and D3, D and D4, and D and D5; and
4. E and E1.

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

5. The facts of A and A1, A and A2, A and A3, A and A4, A and A5 and A and A6; B and B1, B and B2, B and B3, B and B4, and B and B5; C and C1, and C and C2; D and D1, D and D2, D and D3, D and D4, and D and D5; and/or E and E1.

SIXTH THROUGH NINTH SPECIFICATIONS

GROSS INCOMPETENCE

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

6. The facts of A and A1, A and A2, A and A3, A and A4, A and A5, and A and A6;

7. The facts of B and B1, B and B2, B and B3, B and B4, and B and B5;

8. The facts of D and D1, D and D2, D and D3, D and D4, and D and D5; and

9. E and E1.

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

10. The facts of A and A1, A and A2, A and A3, A and A4, A and A5, and A and A6; B and B1, B and B2, B and B3, B and B4, and B and B5; C and C1, and C and C2; D and D1, D and D2, D and D3, D and D4, and D and D5; and/or E and E1.

ELEVENTH THROUGH THIRTEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

11. The facts of A and A1, A and A2, A and A3, A and A4, A and A5, and A and A6;

12. The facts of B and B1, B and B2, B and B3, B and B4, and B and B5; and

13. The facts of C and C1, and C and C2.

FOURTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in New York Education 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:

14. The facts of A and A7, B and B6, C and C3, and D and D6.

DATE: September 25, 2012
Albany, New York

REDACTED

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX II

Dham Gupta, M.D. Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Menands, New York 12204-2719; 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. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is 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 section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. 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.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

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

8. Respondent shall enroll in and complete a continuing education program in the area of medical ethics, as well as a program in medical record-keeping. Said continuing education programs shall be subject to the prior written approval of the Director of OPMC and be completed year of suspension. Respondent shall not resume the practice of medicine until said courses have been successfully completed.

9. Before Respondent resumes the active practice of medicine pursuant to these Terms of Probation, he shall undergo a psychiatric evaluation by a board-certified psychiatrist, acceptable to the Director of the Office of Professional Medical Conduct, and shall be required to demonstrate that he is compliance with all treatment recommendations of said psychiatrist. The costs of the said evaluation and all compliance activities shall be the sole responsibility of Respondent.

10. 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.