These charges are only allegations which may be contested by the licensee in an Administrative hearing.

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

IN THE MATTER OF SAMEH WAHBA, M.D.

STATEMENT

OF

CHARGES

SAMEH WAHBA, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 9, 1994, by the issuance of license number 196839 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, a board-certified psychiatrist, treated Patient A from on or about July 11, 2017 through on or about October 31, 2018. (Patient names are listed in the Appendix.) Respondent's care deviated from minimally accepted standards in that he:

1. Engaged in an inappropriate, sexualized relationship with the patient, and
2. Failed to:
   a. perform and/or note an adequate and thorough diagnostic assessment, and/or
   b. devise and implement an appropriate treatment plan, and/or
   c. appropriately follow-up on and/or reassess treatment, and/or
   d. communicate and/or collaborate with other treatment providers, and/or
   e. adequately and appropriately follow-up on patient hospitalizations, and/or
   f. maintain an accurate record of the evaluation and treatment rendered to the patient
3. Inappropriately:

a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or

b. prescribed controlled substance medications, with high risk for misuse, including but not limited to Xanax and Adderall, without appropriate medical rationale.

B. Respondent treated Patient B from on or about May 6, 2015 through in or about August 18, 2015. Patient B expired on September 5, 2015. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:

a. perform and/or note an adequate and thorough diagnostic assessment, and/or

b. utilize non-prescription treatment modalities, and/or

c. ensure appropriate treatment for addiction, and/or

d. devise and implement an appropriate treatment plan, and/or

e. appropriately utilize toxicology testing and/or respond to toxicology results, and/or

f. appropriately follow-up on and/or reassess treatment, and/or

g. appropriately respond to evidence of possible misuse of prescribed medications, and/or

h. maintain an accurate record of the evaluation and treatment rendered to the patient.

2. Inappropriately:

a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or

b. treated for addiction without a multi-modality plan, and/or

c. prescribed controlled substance medications, with high risk for misuse, including but not limited to Xanax, without appropriate medical rationale, and/or

d. prescribed buprenorphine without following appropriate protocols.

C. Respondent treated Patient C (spouse of Patient D) from on or about September 29, 2009 through in or about February 23, 2016. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:
   a. perform and/or note an adequate and thorough diagnostic assessment, and/or
   b. devise and implement an appropriate treatment plan, and/or
   c. appropriately follow-up on and/or reassess treatment, and/or
   d. appropriately respond to evidence of possible misuse and/or side effects of prescribed medications, and/or
   e. adequately and appropriately follow-up on patient hospitalizations, and/or
   f. appropriately utilize toxicology testing and/or respond to toxicology results, and/or
   g. maintain an accurate record of the evaluation and treatment rendered to the patient.
2. Inappropriately:
   a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or
   b. prescribed controlled substance medications, with high risk for misuse, without appropriate medical rationale.

D. Respondent treated Patient D (spouse of Patient C) on or about June 30, 2008, and then from on or about August 14, 2014 through in or about February 23, 2016. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:
   a. Perform and/or note an adequate and thorough diagnostic assessment, and/or
   b. devise and implement an appropriate treatment plan, and/or
   c. appropriately follow-up on and/or reassess treatment, and/or

d. appropriately respond to evidence of possible misuse and/or side effects of prescribed medications, and/or

e. adequately and appropriately follow-up on patient hospitalizations, and/or

f. appropriately utilize toxicology testing and/or respond to toxicology results, and/or

g. maintain an accurate record of the evaluation and treatment rendered to the patient.

2. Inappropriately:

a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or

b. prescribed controlled substance medications, with high risk for misuse, without appropriate medical rationale.

E. Respondent treated Patient E from on or about December 8, 2014 through in or about September 20, 2016. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:

a. perform and/or note an adequate and thorough diagnostic assessment, and/or

b. devise and implement an appropriate treatment plan, and/or

c. appropriately follow-up on and/or reassess treatment, and/or

d. appropriately respond to evidence of possible misuse and/or side effects of prescribed medications, and/or

e. appropriately address potentially new symptoms, including but not limited to disorganized thoughts and paranoia, and/or

f. appropriately assess risk of self harm, and/or

g. maintain an accurate record of the evaluation and treatment rendered to the patient.

2. Inappropriately:

a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or

b. prescribed controlled substance medications, with high risk for misuse, including but not limited to Xanax and Adderall, without appropriate medical rationale, and/or

c. Prescribed Orap [pimozide, an antipsychotic medication] without appropriate medical rationale, and/or

d. Prescribed medications without considering potential side effects and/or interactions with other medications.

F. Respondent treated Patient F from on or about January 2, 2013 through in or about June 9, 2016. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:

a. perform and/or note an adequate and thorough diagnostic assessment, and/or

b. devise and implement an appropriate treatment plan, and/or

c. appropriately follow-up on and/or reassess treatment, and/or

d. adequately and appropriately follow-up on patient hospitalizations, and/or

e. appropriately respond to evidence of possible misuse and/or side effects of prescribed medications, and/or

f. maintain an accurate record of the evaluation and treatment rendered to the patient.

2. Inappropriately:

a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or

b. prescribed controlled substance medications, with high risk for misuse, including but not limited to Klonopin, without appropriate medical rationale.

G. Respondent treated Patient G from on or about April 16, 1998 through in April 15, 1999 and then from on or about July 2, 2001 through in or about June 29, 2016. Respondent's care deviated from minimally accepted standards in that he:

1. Failed to:
   a. perform and/or note an adequate and thorough diagnostic assessment, and/or
   b. devise and implement an appropriate treatment plan, and/or
   c. appropriately follow-up on and/or reassess treatment, and/or
   d. appropriately respond to evidence of possible side effects of prescribed medications, and/or
   e. appropriately address potentially new symptoms, including but not limited to issues with short term memory, and/or
   f. appropriately utilize toxicology testing and/or respond to toxicology results, and/or
   g. maintain an accurate record of the evaluation and treatment rendered to the patient.
2. Inappropriately:
   a. Treated the patient and/or modified treatment, without appropriate medical rationale, and/or
   b. prescribed controlled substance medications, with high risk for misuse, without appropriate medical rationale.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. 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:

1. Paragraph A and A(1).

SECOND SPECIFICATION

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:

2. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and /or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

THIRD SPECIFICATION

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:

3. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

FOURTH - TENTH SPECIFICATIONS

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:

4. Paragraph A and its subparagraphs.
5. Paragraph B and its subparagraphs.
6. Paragraph C and its subparagraphs.
7. Paragraph D and its subparagraphs.

8. Paragraph E and its subparagraphs.

9. Paragraph F and its subparagraphs.

10. Paragraph G and its subparagraphs.

ELEVENTH - SEVENTEENTH SPECIFICATIONS

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:

11. Paragraph A and its subparagraphs.

12. Paragraph B and its subparagraphs.

13. Paragraph C and its subparagraphs.

14. Paragraph D and its subparagraphs.

15. Paragraph E and its subparagraphs.

16. Paragraph F and its subparagraphs

17. Paragraph G and its subparagraphs.

EIGHTEENTH – TWENTY FOURTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

18. Paragraph A and A(2)(f).

19. Paragraph B and B(1)(h).

20. Paragraph C and C(1)(g).

21. Paragraph D and D(1)(g).

22. Paragraph E and E(1)(g).

23. Paragraph F and F(1)(f).

24. Paragraph G and G(1)(g)

DATE: September 3, 2019
New York, New York

[redacted]

Henry Weintraub
Chief Counsel
Bureau of Professional Medical Conduct