COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Medicine

John Hasty
Director of the Department

Warren W. Koontz, M.D.
Executive Director of the Board

6606 West Broad Street
4th Floor
Richmond, Virginia 23230-1717
(804) 662-9908
FAX (804) 662-9943

February 23, 1998

Nazir A. Chaudhary, M.D.
P. O. Box 13135
Richmond, VA 23225

CERTIFIED MAIL
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RE: License No.: 0101-027959

Dear Dr. Chaudhary:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on Thursday, March 26, 1998, at 9:30 a.m., at the Department of Health Professions, 6606 West Broad Street, Richmond, Virginia. The conference will be conducted pursuant to Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will inquire into allegations that you may have violated certain laws governing the practice of medicine in Virginia. Specifically, you may have violated Section 54.1-2915(A)(3), as further defined in Section 54.1-2914(A)(9) and (10) of the Code, in that:

1. From on or about April 6, 1988 to February 18, 1990, you provided treatment to Patient A, a resident of Forest Hill Manor ("Forest Hill"), Richmond, Virginia, for schizophrenia. During this period, you prescribed Haldol (Schedule IV) and Cogentin (Schedule VI), failing to adequately monitor the patient for possible adverse reactions as a result of extended use of these medications. On or about February 18, 1990, Patient A collapsed at the Forest Hill and expired of cardiac arrest subsequent to being transferred to the hospital.

2. From on or about June 14, 1990 to July 15, 1991, during the course of your treatment of Patient B, a resident of Bellamy Home for Adults ("Bellamy"), Richmond, Virginia, for schizophrenia, you failed to adequately monitor the patient, who had a fifteen (15) year medication history of Haldol and Cogentin use. On July 15, 1991, Patient B was transferred from Bellamy to the Metropolitan Hospital ("Metropolitan"), Richmond, Virginia, Emergency Room with a complaint of cramping in his left hand. Subsequently, the patient was discharged the same day with a diagnosis of mild dystonic reaction. Upon notification by Metropolitan Emergency Room staff of Patient B's discharge to Bellamy with dosage changes in medications, to include a decrease in Haldol from 40mg per day to 30mg per day and an increase in Cogentin from 2mg per day to 2mg

three (3) times per day, you failed to follow-up with the patient for evaluation and monitoring of medications pursuant to the discharging physician's order. As a result, on July 23, 1991, Patient B died of hyperthermia.

3. On or about February 2, 1995, at approximately 5:00 p.m., upon referral by Mary Washington Hospital ("Mary Washington"), Fredericksburg, Virginia, Resident C was placed at Kenmore Forest Home for Adults ("Kenmore"), an adult home in which you have an interest. By your own admission, Resident C had not been officially admitted to Kenmore. Further, you had not seen the resident nor had you been designated as the Resident C's treating physician. At approximately 6:00 p.m., Resident C complained of chest pains to Kenmore staff and was subsequently transferred to the Emergency Room at Chippenham Hospital, Richmond, Virginia. The patient was treated and discharged to be returned to Kenmore. Upon learning of his discharge to Kenmore, Resident C became upset and agitated and was temporarily placed by the Emergency Room treating physician, in Monument Manor, Richmond, Virginia, an adult home in which he had an interest. On or about February 3, 1995, after being informed that Resident C was not returned to Kenmore, you had a Temporary Detention Order issued to Monument Manor reporting that the resident "wanders; [and is] confused," which was unsubstantiated by consultation notes provided to you by Mary Washington.

4. From approximately 1989 to 1990:

A. While acting as the attending physician for the residents of Brook Haven Rest Home, Richmond, Virginia, you provided inadequate and substandard psychiatric services to include medication monitoring and independent counseling for approximately 30 to 35 residents in that you routinely completed these treatments within an half hour for all residents in the facility.

B. While acting as the attending physician for the residents of Shellette's Home for Adults, Richmond, Virginia, you provided substandard care in that you routinely failed to appear for scheduled appointments. When you did provide treatment, you counseled residents using a standard list of questions which did not vary with the functioning level of each resident.

In order to protect the privacy of Patients A, B and C, the patients have been referred to by letter only. Please see Attachment I of this notice for the identity of the individuals referenced above. The following actions may be taken by this Committee:

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;

2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice medicine in Virginia;

3. The Committee may reprimand or censure you, or;

4. The Committee may place you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine in Virginia.