

State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline



IN THE MATTER OF:
Gyan Pareek M.D.
License Number MD 11734
Case # 180577

CONSENT ORDER

Gyan Pareek, M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. The Board of Medical Licensure and Discipline (hereinafter the "Board") makes the following:

FINDINGS OF FACT

1. The Rhode Island Board of Medical Licensure and Discipline (hereinafter "Board") has reviewed and investigated the above referenced complaint pertaining to Dr. Gyan Pareek (hereinafter "Respondent") through its Investigative Committee.
2. Respondent has been a licensed physician in the State of Rhode Island since March 9th, 2005. He is a graduate of St. Georges University School of Medicine on May 15th, 1998. His primary specialty is Urology. His practice is located at Brown Urology, formerly known as University Urology Associates, Suite 201, 195 Collyer Street, Providence, Rhode Island.
3. The Board received a notice of settlement from the National Practitioner Data Bank (NPDB) of a settlement of a malpractice action regarding care delivered to Patient A by Respondent.

4. Patient A was a patient of Brown Urology and was being followed for an elevated PSA level and kidney stones by a Physician Assistant employed by Brown Urology.
5. The Physician Assistant saw Patient A on multiple occasions. Patient A's kidney stone was asymptomatic. The Physician Assistant recorded the location of the asymptomatic kidney stone as lodged in the right kidney on multiple occasions in the medical record. On January 8, 2018, the Physician Assistant changed the location of the kidney stones from the right to the left side. The Physician Assistant requested that respondent see patient A in consultation to evaluate him for left sided kidney stones and a surgical procedure known as ureteroscopy laser lithotripsy. Respondent agreed and saw patient A at a pre-procedure office visit for the first time on March 16, 2016. The purpose of the visit was to evaluate patient A, review the medical record and the advice of the Physician Assistant including his description of the kidney stones as being on the left side. Respondent discussed the proposed procedure with the Physician Assistant and Patient A, and obtained Patient A's informed consent to perform a procedure on his left kidney.
6. Respondent did not review the original diagnostic imaging instead relying on the representations of the Physician Assistant who had been following Patient A.
7. Respondent determined Patient A had kidney stones and would benefit from a diagnostic ureteroscopy of the left kidney.
8. Patient A agreed to and consented to the procedure for his left kidney. Respondent scheduled the aforementioned laser lithotripsy ureteroscopy for Patient A for the left kidney. Patient A had the procedure completed on April 8th, 2016. It was noted during the procedure which lasted approximately four minutes that no stone was detected in the left kidney. Respondent ordered a repeat ultrasound, as was part of his usual practice 6 weeks after the procedure and learned there was a 9 mm kidney stone in the right kidney. An x-ray completed around the same time confirmed the existence of a kidney stone on the right side. It was then learned that the kidney stone was evident in an ultrasound on the right side.
9. Patient A had an unnecessary surgical procedure and had to have the procedure repeated on the correct (right) side on a subsequent date.

10. The Investigative Committee concluded Respondent had not met the minimum standard of care by not referring to the original diagnostic imaging report and verifying the correct location of the kidney stone. The Investigative Committee noted the patient was asymptomatic and could not have been expected to know where his kidney stone was located.
11. Respondent violated Rhode Island General Laws, specifically, § 5-37-5.1 (19) *Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision;*

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board.
2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board, and this Consent Order is not binding on Respondent until final ratification by the Board.
3. If ratified by the Board, Respondent hereby acknowledges and waives:
 - a. The right to appear personally or by counsel or both before the Board;
 - b. The right to produce witnesses and evidence on his behalf at a hearing;
 - c. The right to cross examine witnesses;
 - d. The right to have subpoenas issued by the Board;

- e. The right to further procedural steps except for those specifically contained herein;
 - f. Any and all rights of appeal of this Consent Order; and
 - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.
 - h. Any objection that this Consent Order will be reported to the National Practitioner Data Bank, Federation of State Medical Boards as well as posted on the department's public web site.
4. Respondent agrees to pay within (60) days of the ratification of this Consent Order an administrative fee to the Board with a check for \$850 dollars made payable to the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint.
5. Respondent hereby agrees to this reprimand on his physician license.
6. Respondent agrees to take within six (6) months of the ratification of this order a Board approved CME of at least 8 hours duration in topics related to; patient safety, universal protocol or risk management.
7. In the event that any term of this Consent Order is violated, the Director of the Department of Health shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within twenty (20) days of the suspension and/or further discipline. The Director of the Department of Health shall also have the discretion to request an administrative hearing after notice to


Respondent of a violation of any term of this Consent Order. The Board may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 22 day of February, 2019.



Gyan Pareek M.D.

Ratified by the Board of Medical Licensure and Discipline on the 13th day of March 2019.



Nicole Alexander-Scott, M.D., M.P.H.
Director
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