STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Tania K. Sarkaria, MD	)	Docket Nos. MPS 175-0823 and MPS 067-0424

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont, pursuant to 26 V.S.A. § 1370(b)(3), and alleges as follows:

1. Tania K. Sarkaria, MD, ("Respondent") of Norwich, Vermont holds Vermont medical license number 042.0015012 first issued by the Vermont Board of Medical Practice on October 7, 2020. Respondent is a psychiatrist with a specialty in child and adolescent psychiatry.

2. Jurisdiction in this matter vests with the Board pursuant to 26 V.S.A. §§ 1353-1354, 1370-1376, 3 V.S.A. §§ 809-814, and the Rules of Vermont Board of Medical Practice, to include but not limited to, Sections 3, 25, 43, 45.1.3, and 46.

I. Background

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3. The Vermont Board of Medical Practice ("the Board") opened the first investigation into Respondent's conduct after it received a complaint on July 10, 2023 from the parents of a former patient of Respondent (hereinafter referred to as "Patient 1").

4. The Board assigned this investigation to the Board's South Investigative Committee ("the Committee") for further investigation. As a result of that investigation, the State alleges the following facts.

5. Respondent began treating Patient 1 in 2021 when Patient 1 was nineteen years old. Patient 1 has been diagnosed with developmental disabilities and has co-occurring seizures, mental health conditions, and a cardiac condition. Patient 1 also meets the criteria for autism spectrum disorder. Patient 1's medical history includes hospitalizations for behavioral and psychiatric conditions.

6. Patient 1's parents have a voluntary guardianship for their adult child, Patient 1. The Vermont Superior Court Orange Probate Division issued an order granting that guardianship in 2020. The probate court granted both parents, among other enumerated guardianship powers, the power to "give or withhold consent to medical or dental treatment" subject to Patient 1's legal protections and constitutional rights.

7. Patient 1's guardians provided their guardianship paperwork to Respondent at the beginning of her treatment relationship with Patient 1. Respondent thereafter consulted with them and involved them in shared decision-making in their capacity as legal guardians, referring to them as the guardians in her medical documentation of Patient 1's treatment.

8. Respondent did not retain the guardianship paperwork she was provided by the guardians at the beginning of her treatment relationship of Patient 1.

9. Approximately eighteen months into Patient 1's treatment relationship with Respondent, Patient 1 was hospitalized for suicidality. Respondent wished to make a change to Patient 1's medication several days after Patient 1's discharge from that hospitalization to prescribe Patient 1 Bupropion.

10. Patient 1's guardian (her mother) sent Respondent an email with questions about this medication change. The guardian asked Respondent questions about Bupropion's polypharmacy with another medication that Patient 1 was prescribed, how common it was for patients to experience side effects from the medication, and the medication's safety for a patient with Patient 1's cardiac condition. The guardian expressed that she also wanted the safety of this medication to be reviewed by Patient 1's primary care provider and possibly her cardiologist given her other medical conditions.

11. Respondent responded to this email as a challenge to her professional expertise. Patient 1's father engaged in a lengthy phone call with Respondent to try to assure her that the guardians respected her medical knowledge, but his efforts were unavailing. Within five hours of Patient 1's mother writing the email described in the preceding paragraph, Respondent terminated her treatment relationship with Patient 1 by sending an angry text message to Patient 1's mother.

12. Respondent never formally documented any direct communication to Patient 1 that she was terminating their treatment relationship, and did not formally convey this information to the guardians beyond that above-mentioned text message.

13. Respondent's medical documentation in Patient 1's treatment records includes (1) no documentation at all to Patient 1 about the treatment termination; (2) no documentation to Patient 1's guardians about the termination other than the text message; and (3) no documentation of referrals or communication with Patient 1's primary care provider or other treatment providers and treatment team members arranging for continuity of care.

14. Respondent prescribed one of Patient 1's psychiatric medications for an additional week after terminating their physician patient relationship, and Patient 1 appeared to have two refills left of her remaining psychiatric medication. Respondent did not document any communication with Patient 1's primary care provider or other treatment providers to plan for Patient 1's future medication management despite her stated concern for Patient 1's significant suicidality.

15. Patient 1's guardians sent Respondent an email seven days after the termination of the physician-patient relationship requesting that Respondent transfer Patient 1's medical records to her primary care provider to facilitate continuity of care. Upon receiving no response from Respondent, the guardians followed their request with a second email, and a phone call. Respondent did not timely respond to either method of communication.

16. Respondent did not respond to the guardians' request that Patient 1's medical records be sent to her primary care provider for over eleven months. Attempts by Patient 1's care team to obtain Patient 1's records from Respondent were similarly unsuccessful.

17. After eight months had passed from the guardians' requests to the Respondent for records without a response, Patient 1's guardians filed a complaint with the Board about Respondent's failure to provide Patient 1's medical records to her primary care provider.

18. After learning of the complaint to the Board, Respondent contacted the guardians about the medical records. This was Respondent's first contact with the guardians about Patient 1's medical records since their initial requests eleven months earlier to have the records transferred to Patient 1's primary care provider. Although Respondent had earlier acknowledged the guardians' guardianship status, Respondent asked them to send her another copy of the probate court documentation and an additional signed release before she would release the records.

19. Respondent continued to communicate with the guardians about getting the necessary documentation to release the medical records. Over this series of communications with the guardians, Respondent began to express the view that the guardians could not legally sign the release on Patient 1's behalf and ultimately Respondent questioned the legitimacy of their guardianship itself. Respondent claimed inaccurately in these communications that the guardians had never been granted medical decision-making power by the probate court. Respondent also accused the guardians of malfeasance for their request that she transfer records to Patient 1's primary care provider and threatened to contact social services. She threatened to report them to the district attorney. The Board's investigation into Respondent's conduct remained ongoing during the period that Respondent was communicating with the guardians in this manner.

20. Respondent wrote the Board on November 10, 2023. In this letter, which she signed, she acknowledged that she now had all the documentation she needed to provide Patient 1's primary care provider with a copy of Patient 1's records including a release signed by Patient 1 herself. She told the Board that she would provide Patient 1's records to her primary care provider.

21. Respondent did not send Patient 1's medical records to her primary care provider until May 21, 2024, over six months after her November 10, 2023 letter to the Board indicating that she would do so.

22. The Board also requested Patient 1's records from Respondent during their investigation by issuing a subpoena to Respondent for these records. Respondent initially produced records in response to the subpoena that did not correspond to her billing records. Respondent produced no records of medical treatment for several dates on which she had billed insurance for Patient 1's care. She ultimately claimed one of these dates was a billing error. Respondent indicated five months after the Board's subpoena was served that she had located the missing records and produced records for the remaining dates on which she had billed but not previously provided records.

23. During the Committee's investigation into Respondent's conduct, the Board learned that Respondent had never registered with the Vermont Prescription Monitoring System. This is a patient safety measure and a legal requirement for all providers in Vermont who prescribe any Schedule II, III or IV controlled substances.

24. Respondent additionally contacted Patient 1 by email four months after the guardians' complaint to the Board. In that email Respondent wrote "Your parents do

not have the right to make medical or psychiatric decisions for you. You have a basic guardianship, only to help with housing, finance, etc. Voluntary Guardians DO NOT have the right to make mental health/psychiatric decisions. . . ." At the time of this communication, Respondent had not been Patient 1's clinician in over a year, nor is there any record that she had spoken to Patient 1 since terminating treatment. There is additionally no documentation that she knew Patient 1's current mental status at the time she sent this email, nor that she considered its impact upon her former patient.

25. Respondent engaged in additional hostile communications toward the guardians while the Board's investigation into her conduct was ongoing. Respondent accused the guardians of neglect of Patient 1 and indicated that Patient 1's low adaptive functioning was the result of their parenting. Respondent also accused the guardians of showing classic "Munchhausen by proxy," an outdated term she used to describe Factitious Disorder Imposed on Another ("FDIA"). Respondent stated that she was glad that due to the Board complaint they would be publicly exposed as having this condition. She copied other providers on Patient 1's care team on an email making this claim.

26. None of Respondent accusations that the guardians engaged in parental neglect or FDIA are supported by Respondent's own treatment documentation during the period Respondent was Patient 1's psychiatrist.

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27. The Committee also reviewed Respondent's patient records for an additional ten patients which were procured in response to an information request by

another government agency. Respondent had difficulty producing the requested records to this governmental agency. She produced only a portion of the records during her first record production, and after later supplementing this record production, there were still multiple patient appointments for which she had billed but did not produce records. Among the medical recordkeeping deficiencies noted by the Committee were the following:

a) Respondent was required, pursuant to the Vermont Prescription Monitoring System Rule, to run a VPMS query prior to initially prescribing a benzodiazepine for three of her patients. This is a patient safety measure to protect patients from side effects caused by polypharmacy that are potentially dangerous and to detect potential misuse of controlled substances. Respondent was not registered with the Vermont Prescription Monitoring System and thus did not run the required queries.
b) Respondent had missing billing records or treatment notes in eight of the ten patient charts that were part of the state's review of Respondent's medical documentation.
c) Of the ten patient charts Respondent was required to produce to the state, Patient 2 had no clinical records documenting that Respondent ever treated that patient. Eight other patient charts contained aberrancies involving dates, missing elements of documentation, and/or delayed/incorrect signature time stamps that called into question whether the records had been produced at or near the time of treatment. These

aspects of Respondent's medical documentation are outlined in greater detail for several patients below.

d) Respondent provided treatment to a seventeen-year-old with at-risk behaviors including self-harm, hereafter referred to as Patient 2. Respondent could not provide any clinical records of her treatment for Patient 2 in response to the state's request. Despite her lack of treatment records, Respondent billed insurance for four appointments for Patient 2. The Board investigator was also able to determine that Respondent prescribed lorazepam and Vyvanse to Patient 2 during the period she treated this patient.

e) Respondent provided treatment to a thirteen-year-old who suffered from anxiety and a mood disturbance, hereafter Patient 3. Respondent produced no clinical records of her treatment of Patient 3 in response to the state's initial request for records.[1] Respondent's billing records indicate that she provided treatment to Patient 3 eight times in a six-month period between 2021 and 2022. The Board investigator determined that Respondent prescribed Concerta, Focalin, and Adderall to Patient 3 over this treatment period.

f) Respondent's treatment records for Patient 4 include the following medical documentation concerns: no medical record of a telephone visit with

[1] Respondent did produce one treatment record for this patient later in response to the May 31, 2024 audit referenced in paragraph 28 below. That record was not produced in response to the original request for records and contains an inaccurate medication list. Respondent also produced a billing note for an additional appointment in response to the May 31st audit although she never produced a treatment record for this appointment.

Patient 4 for which she billed the patient's insurance indicating the call lasted twenty-one minutes or more, billing for two initial visits with the patient when only one was allowed under billing rules for adult patients, and two records of treatment a week apart with an identical treatment record except for the date.

g) Respondent did not produce any billing records for Patient 5 in response to the State's record request. She made changes to Patient 5's prescription medication over a seven-month period between 2021 and 2022 but did not produce any treatment records to the State for Patient 5 for that period. Respondent also documented that she ordered and reviewed comprehensive labs for Patient 5 to monitor the metabolic side effects of Risperdal, but she did not specify which labs were ordered, document the lab results, or indicate whether Patient 5's results were within the normal range.

h) Respondent's treatment record for Patient 6 is incomplete. Specifically, Respondent is missing treatment records for seven dates for which she billed insurance for Patient 6's care. Respondent billed insurance for eleven appointments for Patient 6 in total, thus she is missing documentation for over sixty percent of the appointments for which she billed insurance for this patient. There are also significant aberrancies in Respondent's medical documentation for Patient 6. Those aberrancies include: Respondent has a record from an appointment in 2022 which was signed a month later. That record describes the patient's crisis stabilization

which occurred four months after the appointment that was purportedly documented by the record, and three months after the date of Respondent's signature on the note. Other examples of documentation aberrancies for Patient 6 include a note for a 2021 appointment signed in 2023 with the last date of service listed inconsistently within the note as having happened on a day in either spring 2022 or mid-winter 2023. In addition, Respondent purportedly signed one note eleven months prior to the date when the treatment was provided and purportedly signed another note a year prior to the treatment date.

i) Respondent's medical record of her treatment for Patient 7, who is an adolescent, is missing documentation of nine treatment dates for which she billed Patient 7's insurance. Respondent additionally billed insurance twice for a psychiatric diagnostic evaluation for Patient 7 without supporting documentation in her records for either encounter.

j) Respondent's medical record of her treatment for Patient 8 is missing documentation of two treatment dates for which she billed Patient 8's insurance. A patient demographics form for Patient 8 was dated January of 2024 for treatment Respondent provided to this patient in 2021 and 2022. Respondent also purportedly signed a medical record for Patient 8 six months prior to the date the treatment was provided.

28. On May 31, 2024, the state conducted a further audit of Respondent's medical recordkeeping. State auditors went to Respondent's medical practice to review her medical documentation. This meeting had been scheduled with Respondent for this

purpose in advance. The auditors requested medical records for specific appointments for which Respondent had billed for thirteen patients. The requested records spanned a multi-year period from 2021 to 2024. The most current record requested corresponded to an appointment four months prior to the audit. Respondent took an hour to print the records, at one point leaving to get another laptop on which she kept older patient records. At the end of that time, Respondent was only able to produce eleven of the thirty records requested for the chosen thirteen patients. The auditors asked Dr. Sarkaria to confirm whether she had the remaining requested patient records, and she confirmed that she did not.

II. State's Allegations of Unprofessional Conduct

Count 1

29. Paragraphs 1 through 28, above, are restated and incorporated herein by reference.

30. Respondent violated 26 V.S.A. § 1354(b)(1) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient care." 26 V.S.A. § 1354(b)(1).

31. Respondent failed to meet the standard of care pursuant to 26 V.S.A. § 1354(b)(1) when she did not respond to Patient 1's guardians' request to have their daughter's records transferred to her primary care provider for eleven months. Even accepting Respondent's explanation that she believed she needed additional direction

from Patient 1 to disclose the records to her primary care provider, Respondent had a professional responsibility to communicate about and facilitate that record transfer with Patient 1's guardians. Respondent's professional responsibilities were heightened by the fact that Patient 1 had an acute need for psychiatric care at the time her treatment relationship with Respondent ended. Respondent failed to meet her professional duty to facilitate continuity of care for this patient by promptly communicating with Patient 1's guardians about their request for records.

Count 2

32. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

33. Respondent violated 26 V.S.A. § 1354(a)(10) of Vermont's unprofessional conduct statute which states "failure to make available promptly to a person using professional health care services, that person's representative, succeeding health care professionals, or institutions, when given proper written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner" constitutes unprofessional conduct. 26 V.S.A. § 1354(a)(10).

34. Respondent violated 26 V.S.A. § 1354(a)(10) when she did not provide the requested records to Patient 1's primary care provider for approximately five months (on or about November 10, 2023 until on or about May 21, 2024) after assuring the Board that she had the necessary patient permission and would do so.

Count 3

35. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

36. Respondent violated 26 V.S.A. § 1354(a)(4) when she engaged in conduct that constitutes abandonment of a patient.

37. Respondent's termination of her treatment relationship with Patient 1 constituted abandonment. Respondent abruptly terminated her care of Patient 1 without adequate justification for that termination in her medical documentation. At the time Respondent terminated treatment, Patient 1 had recently been experiencing symptoms of suicidality. Respondent never documented any communication with Patient 1 that she was terminating care, and only informally communicated with Patient 1's guardians about the termination in a text message. Respondent additionally did not document any transition planning for Patient 1, who was still in a vulnerable psychological state, including treatment referrals or medication management. Respondent further did not respond to the guardians' efforts to transfer Patient 1's treatment records or make other independent efforts to ensure continuity of psychiatric care for this patient. Respondent's (1) lack of documented explanation or communication with Patient 1 that her treatment was terminating or the rationale for the treatment termination and (2) lack of engagement in documented planning for continuity of treatment for Patient 1 after abruptly terminating the physician-patient relationship both separately and jointly constitute patient abandonment pursuant to 26 V.S.A. § 1354(a)(4).

Count 4

38. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

39. Respondent committed unprofessional conduct, pursuant to 26 V.S.A. § 1354(a)(27), when she failed to comply with the statutes or rules of Vermont governing the practice of medicine. Specifically, Respondent did not comply with Board Rule 43.2.2, which prohibits a Board licensee from:

> …[E]ngaging in any action that may deter a witness from cooperating with a Board investigation and from retaliating against any person based upon the filing of a complaint or cooperation in any way with a Board investigation. Professionals are prohibited from concealing, altering or destroying any evidence that is or may be pertinent to a Board investigation.

40. Respondent violated this Rule by engaging in email conversations with Patient 1's guardians that were hostile and abusive after learning that they had made a complaint to the Board. During this course of conduct, Respondent used the outdated term Munchausen by proxy, a psychiatric diagnosis, to diagnostically label individuals who were not her patients, whom she had never clinically examined, and with no supporting medical documentation. Furthermore, she did so to deter their continued cooperation in a Board investigation. This behavior violates ethical and professional standards. The Board depends on the cooperation of witnesses to fulfill its statutory obligations and protect the public. Respondent used this diagnosis as a form of witness intimidation and shaming during a pending Board investigation, which interferes with the truth-seeking function of the Board. This violation undermines the Board's ability to

effectively regulate the profession and can have the effect of chilling witness participation in Board investigations.

Count 5

41. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

42. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

43. Respondent's conduct above was unprofessional pursuant to 26 V.S.A. § 1354(b)(2) because it did not conform to the essential elements of acceptable and prevailing practice including: (1) terminating her physician patient relationship with Patient 1 without sufficiently documented communication to Patient 1 of that transfer; (2) failing to engage in basic transfer of care planning for medication management and continuity of care for Patient 1 at a time when Patient 1 had recently been discharged from inpatient treatment for suicidality; and (3) engaging in retaliatory behavior against Patient 1's guardians who were trying to facilitate the medical record transfer to their daughter's primary care provider. These factors, separately and together, fail to conform to the essential standards of acceptable and prevailing practice and, therefore, are not competent practice pursuant to 26 V.S.A. § 1354(b)(2).

Count 6

44. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

45. Respondent committed unprofessional conduct, pursuant to 26 V.S.A. § 1354(a)(27), when she failed to comply with the statutes or rules of Vermont governing the practice of medicine. Specifically, It is a legal requirement that each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the Vermont Prescription Monitoring System by November 15, 2013. 18 V.S.A. § 4289(b)(1).

46. Respondent's failure to register with the Vermont Prescription Monitoring System was unprofessional conduct as she failed to comply with that legal requirement which is contained in a statute governing the practice of medicine. 26 V.S.A. § 1354(a)(27).

Count 7

47. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

48. Respondent committed unprofessional conduct, pursuant to 26 V.S.A. § 1354(a)(27), when she failed to comply with the statutes or rules of Vermont governing the practice of medicine. Namely, it is a legal requirement that health care providers, who are required to register with VPMS, query VPMS for patients prescribed benzodiazepines prior to a prescriber issuing their first benzodiazepine prescription

pursuant to VPMS Rule 6.2.5. The Board may find that failure to follow this Rule constitutes unprofessional conduct pursuant to 26 V.S.A. § 1354(a)(27).

49. Respondent was not registered with VPMS and thus did not query VPMS for three of her patients prior to issuing her first benzodiazepine prescription for them as required by VPMS Rule 6.2.5. This presented a patient safety risk as Respondent failed to verify whether these patients were prescribed other medications that would present a polypharmacy risk prior to issuing these prescriptions. Respondent's repeated failure to follow this prescribing rule constitutes unprofessional conduct pursuant to 26 V.S.A. § 1354(a)(27).

Count 8

50. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

51. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

52. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) when she failed to maintain a treatment record of any of her treatment for Patient 2. Maintaining this level of medical documentation is a basic professional responsibility and an essential component of the standard of practice in the medical profession.

Count 9

53. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

54. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

55. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) when she failed to maintain an adequate treatment record of her treatment for Patient 3. Maintaining accurate and reliable medical documentation is a basic professional responsibility and an essential component of the standard of practice in the medical profession.

Count 10

56. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

57. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

58. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) in the provision of care to Patient 4 when she failed to maintain adequate, reliable medical documentation for this patient sufficient to conform to the essential standard of acceptable and prevailing practice.

Count 11

59. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

60. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

61. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) in the provision of care to Patient 5 when she failed to maintain adequate, reliable medical documentation for this patient sufficient to conform to the essential standard of acceptable and prevailing practice.

Count 12

62. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

63. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on

a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

64. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) in the provision of care to Patient 6 when she failed to maintain adequate, reliable medical documentation for this patient sufficient to conform to the essential standard of acceptable and prevailing practice.

Count 13

65. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

66. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

67. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) in the provision of care to Patient 7 when she failed to maintain adequate, reliable medical documentation for this patient sufficient to conform to the essential standard of acceptable and prevailing practice.

Count 14

68. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

69. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

70. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) in the provision of care to Patient 8 when she failed to maintain adequate, reliable medical documentation for this patient sufficient to conform to the essential standard of acceptable and prevailing practice.

Count 15

71. Paragraphs 1 through 28 above are restated and incorporated herein by reference.

72. Respondent violated 26 V.S.A. § 1354(b)(2) of Vermont's unprofessional conduct statute which states, "failure to practice competently by reason of any cause on a single occasion or multiple occasions constitutes unprofessional conduct. Failure to practice competently includes: (2) failure to conform to the essential standards of acceptable or prevailing practice." 26 V.S.A. § 1354(b)(2).

73. Respondent failed to practice competently in violation of 26 V.S.A. § 1354(b)(2) when she produced only eleven of the thirty patient records requested during a scheduled state audit of her medical recordkeeping for thirteen patients and admitted that she did not have the remaining records which had been requested. Her failure to maintain these medical records for these patients did not conform to the essential standards of acceptable or prevailing practice.

WHEREFORE, Petitioner, the State of Vermont, moves the Board to issue an Order that:

(1) Respondent shall be reprimanded for the conduct above;

(2) Respondent shall pay an administrative penalty of a minimum of $12,000.00 in accordance with 26 V.S.A. § 1374(b)(2)(A)(iii);

(3) Respondent's Vermont medical license shall be conditioned to require the following:

a. successful completion of two eight-hour or more AMA PRA Category 1 continuing medical education ("CME") courses on the following topics: (1) medical documentation and recordkeeping, and (2) medical ethics with an emphasis on professional boundaries;
b. five-year period of practice monitoring with a practice monitor approved by the South Investigative Committee of the Board;

c. a practice mentor who is approved by the South Investigative Committee of the Board and shall provide professional mentoring to Respondent for three years;

(4) Take any additional disciplinary action against the medical license of Respondent Tania K. Sarkaria, MD permitted by 26 V.S.A. §§ 1374(b) and/or 1398 as it deems proper.

Dated at Waterbury, Vermont this _10th__ day of June, 2025.

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

By: David K. Herlihy Digitally signed by David K. Herlihy Date: 2025.06.10 13:57:44 -04'00'

David K. Herlihy
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