Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

April 26, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Muhammad Hena, M.D.
4 Atrium Drive, Suite 220
Albany, New York 12205

Jude Mulvey, Esq.
NYS Department of Health
ESP-Corning Tower, Room 2512
Albany, New York 12237-0032

Mae A. D'Agostino, Esq.
D'Agostino, Krackeler, Maguire & Cardona
The Sage Mansion
16 Sage Estates
Menands, New York 12204

RE: In the Matter of Muhammad Hena, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-205) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of Muhammad Hena, M.D. (Respondent) A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	Administrative Review Board (ARB) Determination and Order No. 09-205 COPY

Before ARB Members D'Anna, Pellman, Wagle, Wilson and Milone
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Jude Mulvey, Esq.
For the Respondent: Mae A. D'Agostino, Esq.

After a hearing below, a BPMC Committee found that the Respondent practiced with negligence on more than one occasion and failed to maintain accurate records in treating two persons (Patients A and B). The Committee voted to place the Respondent on probation for two years, with a practice monitor. In this review proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2009), the Petitioner requests that the ARB modify the Committee's Determination by sustaining additional charges and the Respondent requests that the ARB modify the Determination and reduce the penalty. After reviewing hearing record and the parties' submissions, the ARB votes 5-0 to affirm the Committee's Determination to place the Respondent on probation with a monitor and we vote 4-1 to overturn the Committee and sustain the charge that the Respondent practiced with gross negligence. On our own motion, the ARB votes 3-2 to suspend the Respondent's License to practice for two years and to stay the suspension in full.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(2-4) & 6530(32)(McKinney 2010) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence, and,
- failing to maintain accurate patient records.

The charges related to the surgical care which the Respondent provided to two persons in 2002 (Patient A) and in 2005 (Patient B). The Respondent performed surgery on Patient A to relieve colon obstruction. During the hearing, the Respondent conceded to making an error during surgery and the Petitioner withdrew the charge that the Respondent made a fraudulent statement concerning the error. The concession and withdrawal left the Committee to determine whether the Respondent failed to respond appropriately to complications from the surgery and made an inaccurate statement in the medical record concerning surgical misadventures. The Committee also considered whether the Respondent failed to respond to complications following the surgery on Patient B, assess the Patient appropriately before discharge, record entries adequately and prepare an adequate, accurate and/or timely discharge summary. Following the hearing, the Committee rendered their decisions on those issues in the Determination now under review.

The Committee found that the surgery on Patient A was to include an ileostomy, in which the Respondent would bring the distal portion of the bowel, or the ileum, to the skin as a stoma through which waste products could exit the body (Hearing Transcript pages 17-18, 232). The Respondent brought the distal colon out as a stoma, rather than the distal bowel, so that waste products were unable to exit through the skin and later exited through an emplaced nasogastric tube. The Committee found further that after four or five days post-surgery, during which the ileostomy failed to function, the Respondent should have investigated the non-functioning ileostomy, but failed to do so. The Respondent performed a Whipple procedure on Patient B, which required the Respondent to join limbs of the bowel to something else using sutures

(anastomoses). Linkage at the suture points poses a common complication from the surgery and requires the surgeon to appreciate and react in a timely fashion to indications of leakage such as abdominal pain or any signs of infection. The Committee found that Patient B presented with such symptoms, but that the Respondent failed to run tests or perform an examination. The Committee found further that the Respondent failed to perform an appropriate assessment on the Patient's suitability for discharge from the hospital following the surgery and failed to record a discharge summary.

The Committee determined that the Respondent practiced with negligence on more than one occasion in treating Patients A and B and that the Respondent failed to maintain accurate medical records for Patients A and B. The Committee dismissed the charges that the Respondent practiced with gross incompetence in treating either Patient A or B. In making their findings and conclusions, the Committee indicated that they relied on testimony by the Petitioner's expert witness, Michael Rade, M.D., and disregarded testimony by the Respondent's expert witness, Neil Lempert, M.D. The Committee found no bias on the part of Dr. Rade and the Committee found Dr. Rade forthright in manner and knowledgeable concerning general surgery. The Committee found Dr. Lempert's testimony non-credible and superfluous. The Committee noted that Dr. Lempert had not practiced actively for years, assumed facts not in evidence and acted as an advocate rather than an objective expert witness.

The Committee voted to place the Respondent on probation for two years under the terms that appear at Appendix II to the Committee's Determination. The terms include the requirement that the Respondent practice with a monitor. The Committee stated that the Respondent's technical and surgical skills met the standard of care, but that the record in this case demonstrated the Respondent's deficiencies in post-operative care and showed an insufficient level of involvement in post-operative attention to patients. The Committee concluded that monitoring the Respondent's medical charts would assure that the Respondent's post-operative care meets the standard of care in substance and in documentation.

Review History and Issues

The Committee rendered their Determination on November 16, 2009. This proceeding commenced on November 25 and December 1, 2009, when the Respondent and then the Petitioner filed Notices requesting Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's brief and reply brief. The record closed when the ARB received the reply brief on January 22, 2010.

The Respondent argued that the Petitioner requested that the penalty in this case include a practice monitor on the premise that the Respondent practiced with gross negligence, but the Committee dismissed the gross negligence charges. The Respondent argued further that a practice monitor could infringe on his ability to practice and would impact his ability to participate in certain insurance programs and practice before the New York Worker's Compensation Board (WCB). In addition, the Respondent alleged error by the Committee for rejecting Dr. Lempert as a credible witness and for failing to credit testimony by the Respondent's supervisor, Steven Stain, M.D., to the effect that the Respondent needed no monitor due to the structure in place at the Respondent's current hospital. The Respondent described the cases at issue here as isolated and remote instances in an otherwise unblemished career. The Respondent requested that the ARB reduce the penalty to a reprimand only.

The Petitioner argued that the Committee erred in failing to sustain the gross negligence charges relating to performing the procedure inappropriately on Patient A, failing to respond to the complications after the surgery on Patient B and failing to assess Patient B prior to discharge. In reply to the Respondent's brief, the Petitioner alleged that the Respondent's claims about practice before the WCB constituted material from outside the hearing record.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion and that the Respondent failed to maintain accurate records. Neither party challenged the Committee's Determination on those findings. The ARB affirms the Committee's Determination to place the Respondent on probation for two years, under terms that include practice with a monitor. The ARB overturns the Committee and sustains the charge that the Respondent practiced with gross negligence. On our own motion, the ARB majority votes to suspend the Respondent's License for two years and to stay the suspension in full.

The ARB agrees unanimously with the Committee that a sanction in this case must assure that the Respondent has corrected the deficiencies in care that this record reveals. We agree further that probation with a monitor and record review will provide that assurance. We find this penalty less intrusive than a practice supervisor. The Committee found that the Respondent possessed sufficient skills, so no need exists for continuing education. We disagree that structure at a hospital will provide sufficient supervision to make a monitor unnecessary. Hospital structure failed to provide any oversight to prevent the care deficiencies apparent from this record.

The ARB votes 4-1 to overturn the Committee and sustain the charge that the Respondent practiced with gross negligence in treating Patients A and B. Gross negligence can consist of a single, egregious violation of the standard of care or multiple violations of the care standard that amount cumulatively to egregious conduct, Rho v. Ambach, 74 N.Y.2d 318 (1997). With both the Patients at issue in this case, the Respondent failed over the course of several days to respond appropriately to complications from surgery. In the surgery on Patient A, the Respondent committed a fundamental and significant error, which failed to relieve an obstruction in the Patient's colon and which placed the Patient at greater risk. This conduct amounted to gross negligence.

The ARB finds no error by the Committee in failing to credit testimony by the Respondent's witnesses, Dr. Lempert and Dr. Stain. The ARB defers to the Committee in their judgment on witness credibility. The Committee recognized that Dr. Lempert held board certification in general surgery, but the Committee also noted that Dr. Lempert had not practiced actively for several years and testified by assuming matters not in the record. Dr. Stain testified that no monitor was necessary over the Respondent's practice due to structure in place at the Respondent's current practice site. The ARB has stated already that the structure in place at the Respondent's prior hospital failed to prevent the deficiencies in care that the Respondent demonstrated in treating Patients A and B.

As we noted earlier in this Determination, the ARB may choose to substitute our judgment and impose a more severe sanction than the Committee, on our own motion, without either party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, (supra). The ARB votes 3-2 to substitute our judgment, on our own motion, in this case. The majority concludes that practicing with gross negligence in two cases warrants a two-year

suspension in the Respondent's License. The majority votes further to stay the suspension in full, because we agree with the other ARB members that probation with a monitor will provide proper oversight to assure that the Respondent has corrected the deficiencies in his practice.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent practiced with negligence on more than one occasion and failed to maintain accurate records.
2. The ARB overturns the Committee and sustains the charges that the Respondent practiced with gross negligence in treating Patients A and B.
3. The ARB affirms the Committee's Determination to place the Respondent on probation for two years under the Probation Terms that appear at Appendix II to the Committee's Determination.
4. The ARB votes 3-2 to suspend the Respondent's License for two years and to stay the suspension in full.

Thea Graves Pellman
Datta G. Wagle, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Muhammad Hena, M.D.

Thea Graves Pellman, an ARB Member affirms that she took part in the deliberations in this case and that this Determination reflects the decision of the majority in the matter of Dr. Hena.

Dated: March 29, 2010

REDACTED

Thea Graves Pellman

In the Matter of Muhammad Hena, M.D.

Linda Prescott Wilson, an ARB Member affirms that she took part in the deliberations in this case and that this Determination reflects the decision of the majority in the matter of Dr. Hena.

Dated: 30 March, 2010

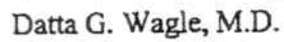
REDACTED

Linda Prescott Wilson

In the Matter of Muhammad Hena, M.D.

Datta G. Wagle, M.D., an ARB Member affirms that she took part in the deliberations in this case and that this Determination reflects the decision of the majority in the matter of Dr. Hena.

Dated: 3/29/, 2010



REDACTED

Datta G. Wagle, M.D.

In the Matter of Muhammad Hena, M.D.

Richard D. Milone, an ARB Member affirms that she took part in the deliberations in this case and that this Determination reflects the decision of the majority in the matter of Dr. Hena.

Dated: April 23, 2010

REDACTED

Richard D. Milone, M.D.

In the Matter of Muhammad Hena, M.D.

John A. D'Anna, M.D., an ARB Member affirms that she took part in the deliberations in this case and that this Determination reflects the decision of the majority in the matter of Dr. Hena.

Dated: March 29th, 2010

REDACTED

John A. D'Anna, M.D.