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

November 16, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Muhammad Hena, M.D.
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Corning Tower, Room 2512
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Albany, New York 12237-0032

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

Dear Parties:

Enclosed please find the Determination and Order (No. 09-205) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

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

COPY

IN THE MATTER

OF

MUHAMMAD HENA, M.D.

DETERMINATION

AND

ORDER

BPMC No. 09-205

A Notice of Hearing and Statement of Charges dated March 16, 2004, were served upon the Respondent, **MUHAMMAD HENA, M.D.** **PETER B . KANE, M.D., Chair, ARTHUR S. HENGERER, M.D.** and **JANET M. MILLER, R.N.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter "the Committee") in this matter pursuant to §230(10)(e) of the Public Health Law. **JEFFREY KIMMER, Administrative Law Judge**, served as the Administrative Officer for the Hearing Committee.

The Department of Health appeared by **JUDE MULVEY, ESQ.,** Associate Counsel. The Respondent appeared by **D'Agostino, Krackeler, Maguire & Cardona, MAE A. D'AGOSTINO, ESQ.,** of Counsel.

Evidence was received, witnesses sworn and heard, and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing & Statement of Charges:	March 16. 2009
Date of Hearing:	May 8, 2009 May 26, 2009 July 16, 2009
Date of Deliberations:	September 22, 2009

STATEMENT OF CASE

Initially, the Statement of Charges alleged the Respondent violated four categories of professional misconduct. Subsequently the Department withdrew the allegation of fraud. The remaining alleged specifications of misconduct were gross negligence, negligence on more than one occasion, and failure to maintain accurate patient records.

The charges relate to two surgeries the Respondent performed, one in November 2002 and one in October 2005, and the care provided subsequent to those surgeries.

A copy of the Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I. (**NOTE: The Department withdrew factual allegations A.3 and B.3, and the fourth specification. Fraud, from the Statement of Charges.)**

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in

this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Muhammad Hena, M.D. (hereinafter "Respondent", was authorized to practice medicine in New York State on or about August 1, 1972, by the issuance of license number 113461 by the New York State Education Department (Ex. 3).

PATIENT A:

2. Patient A was a sixty-two (62) year old male who received medical care from the Respondent. The patient had a pre-operative history of an obstructed colon. On or about November 10, 2002, the Respondent performed surgery on Patient A, including a subtotal colectomy. During the surgery the Respondent inappropriately performed an ileostomy by using distal colon for the stoma instead of the ileum. (T. 15-19; Ex. 4)

3. During the post-operative period, a physician should, after 5-6 days of a non-functioning ileostomy, conduct a timely and thorough medical investigation to ascertain why the ileostomy is not functioning. The Respondent did not do this.. (T. 24, 28-29, 32 34, 42-43, 67-68, 69; Ex. 4)

4. Patient A's ileostomy did not function post-operatively until a second surgery was

performed on November 27, 2002, to correct the surgical error of the November 10, 2002 surgery. (Ex. 4).

5. In a hospital record dated January 17, 2003, relating to Patient A the Respondent inaccurately certified that there had been "*no surgical misadventure*" with regard to the formation of an external stoma. (T. 44-45; Ex. 4)

PATIENT B:

6. Patient B was a sixty-two (62) year old female who received medical care from the Respondent. On or about October 25, 2005, the Respondent performed surgery, known as a Whipple procedure, on Patient B. (T. 75-76; Ex. 9)

7. The Whipple procedure is a major, complicated, and lengthy surgery which involves three (3) anastomoses. These anastomoses have a potential to leak, which can result in infection. (T. 76-81, 122)

8. On November 4, 2005, the patient had symptoms of nausea, was not taking food by mouth, and had mild abdominal pain. Presented with these symptoms, the Respondent should have run blood laboratory tests and conducted a physical examination on that date. The Respondent did not to this. (T. 85-87, 90-92, 96-97, 123, 132, 134-136; Ex. 9)

9. On the day of discharging a patient, a physician should thoroughly and appropriately assess the patient's suitability for discharge, and record a discharge summary which includes pertinent findings of a physical examination and a summary of the hospitalization. The Respondent did not do this. (T. 96-100, 105, 126-127, 132-134, 139-140; Ex. 9)

10. A physician should create a discharge summary in a timely manner so as to assure

an accurate as possible medical record. The discharge should include pertinent information about the patient's condition on that date, the course of the patient's hospitalization and post-discharge expectations and instructions. (T. 95-96, 99-100, 129-130; Ex. 9) The Respondent did not do this.

CONCLUSIONS

Based on the findings of Fact noted above, the Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A. **(2);**

Paragraph A.1: **(2);**

Paragraph A.2: **(3);**

Paragraph A.4: **(5);**

Paragraph B: **(6);**

Paragraph B.1: **(8);**

Paragraph B.2: **(9);**

Paragraph B.4: **(10).**

As noted above, Factual Allegations **A.3** and **B.3** were **withdrawn** by the Petitioner.

The Committee sustained the following specifications: (The paragraphs noted in parentheses are those factual allegations which were adopted by the Committee and support the particular specification.)

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs A., A.1 and A.2; B., B.1 and B.2.)

FAILING TO MAINTAIN PATIENT RECORDS

Fifth and **Sixth Specifications:** (Paragraph A., A.4; and B., B.4)

The Committee found that the **Second** and **Third Specifications** of practicing with gross negligence were not sustained. As noted above, the **Fourth Specification "fraud"** was withdrawn.

DISCUSSION

Respondent was ultimately charged with **Five Specifications** alleging professional misconduct within the meaning of Education Law §6530, namely negligence on more than one occasion, two incidents of gross negligence, and two incidents of failing to maintain accurate patient records.

The Committee unanimously concluded, by a preponderance of the evidence, that the specifications of negligence on more than one occasion, and failure to maintain accurate patient records should be sustained. The Committee also concluded that the specification of gross negligence should not be sustained. The rationale for the Committee's conclusion is set forth below.

The Petitioner presented Michael Rade, M.D., as its sole expert witness. Dr. Rade is a board certified general surgeon. There was no evidence of any bias on the part of Dr. Rade, or his unsuitability as an expert witness.

The Committee found Dr. Rade credible for the most part and viewed his testimony in favorable light. He answered questions in a forthright manner and was knowledgeable of general surgery. The Committee notes that Dr. Rade had not performed the surgery involved in Patient

B. for a number of years; however the quality of the performance of the surgery itself was not an issue raised in the charges relating to Patient B, but rather the post-op care provided to this patient.

The Respondent presented Neil Lempert, M.D. as its sole expert witness. Dr. Lempert is a board certified general surgeon. The Committee found his testimony to be not credible and superfluous. Dr. Lempert has not practiced actively for a number of years. The Committee found that he did not add anything in support of the Respondent's position. In his testimony he assumed things which were not in evidence, and was found to be an advocate, rather than an objective expert witness. In his testimony he made excuses for the Respondent's failure to act sooner to determine the cause of the ileus with respect to Patient A. It appeared that no matter what the evidence demonstrated, Dr. Lempert found no fault with the Respondent's conduct. This led the Committee to disregard his testimony.

The Respondent also presented Steven Stain, M.D. as a character witness on his behalf.

PATIENT A:

The evidence was uncontested regarding charge **A.1**, that a surgical error occurred.

The Committee was more concerned with the quality of the post-op care that the Respondent provided. The Committee concurred with the Department's expert that after five or six days of a non-functioning ileostomy, the Respondent should have investigated the cause for this, including conducting tests to determine what was going on with this patient, particularly when the indications were this patient was not doing well.

The Committee agreed with Dr. Rade that a physician cannot just assume after a number of days of a non-functioning ileostomy that it's an ileus. A timely and thorough medical investigation was warranted in this patient's case, and it was not conducted.

With respect to allegation **A.4,** the discharge notes and a hospital-generated billing code document signed by the Respondent and dated January 17, 2003 were incorrect. Neither document mentioned the inappropriately performed ileostomy and the billing code document even states there was "*no surgical misadventure*". That was not the case.

PATIENT B:

The Committee concluded that the Respondent did not respond to any of the post-op complications that the patient exhibited. The patient record does not corroborate that the Respondent saw the patient every day post-op. Particularly, on the day before discharge, the record indicated the patient displayed a number of complications which were not addressed by the Respondent. The Committee agrees with the Department's expert that blood work should have been conducted and a CAT scan on that day. This was not done.

There was no record that the Respondent saw the patient on the day of discharge, or that the patient had a physical examination and was found physically ready for discharge on that day. That does not meet the standard of care.

The discharge note for this patient was not dictated until June 19, 2007, more than a year and a half after the actual discharge. Consequently, it was untimely. Neither did the note contain the necessary information that a discharge note should include. It was inaccurate in that it stated the patient was "*doing well*". That statement is not borne out by the medical record and should not have been made since the Respondent did not assess the patient on the day of discharge. The discharge note appears to be constructed from other than an actual memory of events.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be placed on probation for a period of two (2)years.

The terms of the probation are more specifically set forth in Appendix II). This determination was reach upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee concluded that the Respondent's technical and surgical skills met the standard of care.; however, the record in this case established Respondent has deficiencies in his post-operative patient care. The record exhibited problems with the Respondent's post operative care and showed an insufficient level of involvement in the post-operative attention paid to patients.

The Committee felt that the actions of the Respondent warranted a two year period of probation, during which time his medical charts would be monitored to assure his post operative care meets the standard of care in substance and in level of documentation.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First, Fifth and Sixth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED;**
2. The Respondent is placed on **PROBATION FOR TWO (2) YEARS**. The terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Cazenovia, New York
11/16/, 2009

Redacted Signature

PETER B. KANE, M.D., Chair

ARTHUR S. HENGERER, M.D.
JANET M. MILLER, R.N.

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

Mae A. D'Agostino, Esq.
D'Agostino, Krackeler, Maguire & Cardona
The Sage Mansion

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
MUHAMMAD HENA, M.D.	:	CHARGES

----------X

MUHAMMAD HENA, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 1, 1972, by the issuance of license number 113461 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (for reasons of confidentiality, identified only in the attached Appendix), a 62 year old male, from around November 2002, until at least 2004, at his office, 4 Atrium Drive, Suite 230, Albany, New York, and at St. Peter's Hospital, Albany, New York. Respondent's care of Patient A did not meet acceptable standards of care in that:

1. During a procedure that included a subtotal colectomy on November 10, 2002, Respondent inappropriately performed an ileostomy using distal colon rather than ileum.
2. During the post-operative period, Respondent failed to timely and appropriately respond to indications of a non-functioning ileostomy.
3. Respondent failed to document that he notified the patient of the cause of the non-functioning ileostomy.
4. On a document dated January 17, 2003, Respondent fraudulently or inaccurately certified that the following were accurate and complete statements to the best of his knowledge: there had been no surgical misadventure regarding the patient's abnormal reaction to formation of an external stoma; there had been a complication after partial or total organ removal but no surgical misadventure.

B. Respondent treated Patient B, a 62 year old female, in October and November 2005, at his office and at St. Peter's Hospital. Respondent's care of Patient A did not meet acceptable standards of care in that:

1. During the post-operative period following a Whipple procedure, Respondent failed to timely and appropriately respond to indications of a possible post-operative complication.

2. Respondent failed to appropriately assess or cause the patient to be appropriately assessed prior to or the day of discharge.

3. Respondent's record entries are inadequately legible.

4. Respondent prepared a discharge summary dated June 19, 2007, that was untimely, inadequate and/or inaccurate.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of New York Education Law § 6530(3) in that Petitioner charges:

1. The facts of paragraphs A and A.1, A and A.2, A and A.3, B and B.1 and/or B and B.2.

SECOND AND THIRD SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of New York Education Law § 6530(4) in that Petitioner charges:

2. The facts of paragraphs A and A.1, A and A.2 and/or A and A.3.

3. The facts of paragraphs B and B.1 and/or B and B.2.

FOURTH SPECIFICATION

FRAUD

Respondent is charged with practicing the profession fraudulently as defined in New York Education Law § 6530(2) in that Petitioner charges:

4. The facts of paragraphs A and A.4.

FIFTH AND SIXTH SPECIFICATIONS

FAILING TO MAINTAIN PATIENT RECORDS

The Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of New York Education Law § 6530(32) in that the Petitioner charges:

5. The facts of paragraphs A and A.3 and/or A and A.4.

6. The facts of paragraphs B and B.4 and/or B and B.5.

Dated: March 16, 2009
Albany, New York

Redacted Signature

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Terms of Probation

1. The Respondent's license is placed on Probation **for Two (2) years**. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. The Respondent's shall practice medicine during the period of probation only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor. The practice monitor shall on a random basis, at least

monthly, examine a selection (no less than 25 %) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice and in particular his post-operative care, is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. During the first year of the probation period Respondent shall cause the practice monitor to report monthly in writing, to the Director of OPMC. For the remainder of the probation period the monitor shall report on a quarterly basis.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after she receives written notification from the Director of OPMC that the Suspension of her license is lifted.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.