STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

March 31, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Charles M. Momah, M.D.
C/O Robert H. Iseman, Esq.
Iseman, Cunningham, Reister & Hyde
9 Thurlow Terrace
Albany, New York 12203

Michael A. Hiser, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Charles M. Momah, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-69) 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.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

As prescribed by the New York State Public Health Law □230, subdivision 10, paragraph (i), and □230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

CHARLES M. MOMAH, M.D.

DETERMINATION

AND

ORDER

BPMC- 99-69

ANDREW J. MERRITT, M.D., Chairperson, **JAMES O. ROBERSON, M.D.**, and MARY PATRICIA MEAGHER, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **SUSAN S. PATTENAUDE, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges Served:	April 28, 1998
Answer to Statement of Charges:	May 15, 1998
Prehearing Conference:	May 18, 1998

Hearing Dates:[1]	May 27, 1998 June 24, 1998 September 2, 1998 September 9, 1998
Post-Hearing Briefs Served:	October 9, 1998
Deliberation Date:	October 28, 1998
Places of Hearing:	Hampton Inn Syracuse, New York Holiday Inn Syracuse, New York
Petitioner Appeared By:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Michael A. Hiser, Associate Counsel
Respondent Appeared By:	Robert H. Iseman, Esq. Valerie Lape Handy, Esq. Iseman, Cunningham, Riester & Hyde

WITNESSES

For the Petitioner:	K.P. Marlinda LaValley Edward Jacobs, M.D. B.K. Sue Beaulieu
For the Respondent:	Mary Joyce McGinnis, M.D. C.S. Charles M. Momah, M.D.

STATEMENT OF CHARGES

Respondent was authorized to practice medicine in New York State on August 7, 1987 by the issuance of license number 171684 by the New York State Education Department. The

[1]The sixty day time period for the issuance of a determination set forth in Public Health Law Section 230.10(h) was waived by both parties (T. 741-72).

Respondent is not currently registered for the practice of medicine. He was last registered for the practice of medicine for the period January 1, 1995 through June 30, 1997. Respondent was served with a Notice of Hearing and Statement of Charges. dated April 28, 1998. Respondent was charged with misconduct under New York Education Law Sec. 6530.

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine fraudulently, with moral unfitness, with gross negligence and gross incompetence, with negligence on more than one occasion, with incompetence on more than one occasion, and with willfully making or filing a false report.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

GENERAL FINDINGS OF FACT

Having heard testimony and considered evidence presented by the Department of Health and the Respondent, the Hearing Committee hereby makes the following findings. Citations in parentheses refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

1. Respondent Charles M. Momah, M.D. was licensed as a physician in New York State on August 7, 1987, by the issuance of license number 171684 by the New York State Education Department. Respondent is not currently registered with the New York State Education Department. He was last registered to practice as a physician for the period January 1, 1995 through June 30, 1997 with an office address of P.O. Box 5178, Massena, New York, 13662 (Ex. 2).

2. Respondent received his medical training at the University of Nigeria. He served a one year internship in Nigeria, followed by one year of compulsory studies in family medicine. He then trained at McGill University in Montreal, Canada, followed by one year of general surgical training and four years of OB/GYN training, finishing in 1987 (T. 541-42).

3. Respondent was board certified in obstetrics and gynecology by the Royal College of Surgeons of Canada in 1989 (T. 542).

4. After Respondent left Montreal, he worked for eighteen months in New York City for the LaGuardia Medical Group, a Health Maintenance Organization ("HMO") (T. 542-43).

5. Respondent was responsible for all the obstetrics and gynecology work for one of the HMO's eight centers and performed about fifteen deliveries a month at LaGuardia Hospital (T. 543).

6. Respondent practiced in Massena, New York from 1989 through 1993 (T. 548, 593).

7. When the Respondent was recruited to Massena by Massena Memorial Hospital ("MMH" or the "Hospital"), he was concerned about whether there would be adequate coverage, due to the fact that there was only one other OB/GYN practicing in Massena (T. 545-46).

8. The Hospital promised Respondent that he would have adequate backup coverage by the other OB/GYN (T. 546-48, 584).

9. The coverage was not provided, and Respondent had to work or be on call seven days a week, 24 hours a day (T. 582-83).

10. The Respondent testified that at a medical staff meeting during his first week of work at MMH, the Director of Nursing, Roxanne Roberts, gave him a pen and "told me to write to see if I knew how to write." (T. 549).

11. During a meeting with three public health workers at which Ms. Roberts and Respondent were present, the participants discussed why more deliveries occurred at Canton-Potsdam Hospital than Massena Memorial Hospital. After Respondent explained that there were more deliveries at Canton-Potsdam Hospital because there were more doctors performing deliveries, Respondent testified that Ms. Roberts stated that "no, that wasn't the reason; that Massena Hospital doesn't have a white doctor, that patients like to go to doctors who they want the babies to look [like]." (T. 580).

12. The labor and delivery room at the Hospital contained out-of-date equipment and lacked important equipment such as equipment to perform a fetal scalp sampling or an intrauterine pressure monitoring, and the Hospital nursing staff lacked important skills, like interpreting fetal heart rate monitor strips (T. 552-54).

13. The Respondent made oral complaints about problems relating to the equipment and nursing staff skills to the director of nursing, the medical director and Hospital administrator from the time he arrived in Massena (T. 555-56).

14. After the Respondent was told by his friend, Dr. Shehadi, that the Director of Nursing, Ms. Roberts, had stated, "[l]ast month we got rid of Dr. Shehadi; this month in June we'll get rid of Dr. Momah," Dr. Momah began putting his complaints in writing. The Respondent's written complaints included his concerns about the nurses' lack of skills; the fact that one of his patients had been sent away from the Hospital while he was out of town and almost delivered in the taxi on her way to another hospital; and a nurse's inappropriate and unprofessional comments to a patient (T. 556-59, 562, 572; Exs. WW, XX, YY, AAA, CCC).

15. Respondent submitted complaints to the Department and the President of the Board of Managers of the Hospital which summarized the complaints he had previously made to the Hospital (T. 573-74, 576; Exs. EEE. FFF).

16. In response to the Respondent's complaints, the Hospital denied everything and took no corrective action (T. 577-78).

17. While the Respondent was winding up his practice in Massena, he performed locum tenens work in the state of Georgia (T. 593-94).

18. At about the same time, Respondent took numerous continuing medical education courses in the areas of obstetrics, gynecology and infertility, including cases on high-risk pregnancy management and Rh sensitization (T. 596-602, Exs. KK-TT).

19. In November of 1993, the Respondent was board certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology (T. 594-95).

GENERAL CONCLUSIONS

The Respondent was forced to practice in Massena with long hours, little backup coverage or support either from fellow OB/GYN's or Hospital administrators, substandard or absent equipment, nursing skills which were questionable at best, and open hostility and racism. The Respondent's complaints about coverage, equipment and skills were well documented in letters he sent to the Hospital and the Department. It stands to reason that the Respondent would understand that testimony about a racist and hostile environment, even if found to be true by this Committee, would have no bearing on the issue of the Respondent's misconduct. The Hearing Committee believes that nothing would be gained by fabricating such testimony and finds the Respondent's testimony to be credible as to the environment he endured at the Hospital.

The environment and lack of adequate backup, equipment and staff do not in any way excuse Respondent from conducting himself professionally and with due standards of care at all times. However, the Hearing Committee must conclude that these factors made the Respondent's practice more difficult and may have enabled his incidents of misconduct.

FINDINGS OF FACT - PATIENT A

1. The allegations concerning patient A were withdrawn by the Petitioner.

FINDINGS OF FACT - PATIENT B

1. Allegation B.1 was withdrawn by the Petitioner based on the documentary evidence produced and the testimony of the witnesses.

2. The Respondent's privileges at MMH were to end on December 31, 1992 (T. 628). As this time approached, Dr. Momah both sought privileges at Canton-Potsdam Hospital (T. 60-61, 628) and transferred patients to other doctors in the area (T. 629).

3. Dr. Momah frequently called or visited Marlinda LaValley, Vice President for Administrative Services at Canton-Potsdam Hospital, regarding the status of his privileges there (T. 54, 59-60).

4. Dr. Momah did everything he could to complete his application for privileges at Canton-Potsdam Hospital, including giving his permission to MMH to release to Canton-Potsdam everything it needed (T. 75).

5. Because MMH never submitted several documents continuously requested by Canton-Potsdam Hospital, Respondent's application for privileges was never deemed complete (T. 71).

6. Respondent treated Patient B from on or about December 14, 1992 through on or about February 16, 1993, at Respondent's office. Respondent provided prenatal obstetric care to Patient B.

7. Prior to Patient B's first visit to Dr. Momah, she asked Respondent's receptionist whether the Respondent had privileges at Canton-Potsdam Hospital. The receptionist indicated the Respondent had such privileges (T. 36-37, 47-48).

8. During Patient B's first visit to Dr. Momah on December 14, 1992, she made a specific inquiry of the Respondent as to whether he had privileges to deliver at Canton-Potsdam Hospital. Patient B recalled that the Respondent assured her he had privileges there and that it would not be

a problem, that when her baby was born, Patient B would be able to deliver at Canton-Potsdam Hospital (Ex. 5, p. 3; T. 36-37, 47-48, 51).

9. After Patient B's first visit, Respondent opened an office in Potsdam. Patient B heard rumors that Respondent did not have privileges at Canton-Potsdam Hospital. Because of this, she contacted the hospital directly and asked if Respondent had privileges. The representative of the hospital told Patient B that Respondent did not have privileges at Canton-Potsdam Hospital (T. 39-41).

10. After she learned this information directly from the hospital, she made plans to get another physician. She also spoke to Respondent about this issue the last time she saw him, on or about February 16, 1993. She testified that when she questioned Respondent as to why he initially said he had privileges, but later said he "would get" them, Respondent became upset (Ex. 5, p. 3; T. 41-42, 52).

11. During Patient B's first visit to Respondent, he referred Patient B to Dr.. Garcia (T. 630; Ex. 5, p. 3).

12. Dr. Momah saw Patient B on three occasions after her initial visit, through February 16, 1993 (Ex. 5, p. 3).

13. Patient B eventually was transferred to Dr. Garcia, on or after February 16, 1993 (Ex. 5, p.3).

14. It has been almost six years since Patient B has spoken to Dr. Momah (T. 43).

15. Patient B did not take any notes or write any letters concerning her relationship with Dr.. Momah (T. 46).

16. Patient B did not discuss these events with the department until two and one half years after they occurred (T. 46).

17. C.S. was a patient of Dr. Momah whose twins were delivered by Dr. Momah during her second pregnancy (T. 522).

18. When Patient C..S. returned to Dr. Momah for her third pregnancy, Dr. Momah informed her that he did not have hospital privileges, but that he could provide her prenatal care (T. 523).

19. Dr. Momah never told C.S. that he had privileges at canton-Potsdam Hospital (T. 523).

20. Both Patient B and C.S. indicated they liked the care that Dr. Momah provided (T. 50, 525, 527).

CONCLUSIONS - PATIENT B

Both Patient B and C.S. indicated they liked the care that Dr. Momah provided them. Patient B, however, testified that the Respondent told her he had privileges at Canton-Potsdam Hospital, while C.S. testified that the Respondent told her he did not. Both witnesses evinced credibility, but we cannot place enough reliance on the testimony of Patient B to sustain the allegation, as it is simply inconsistent with other evidence and testimony.

Patient B's medical record indicates that she was referred to Dr. Garcia at her initial visit to Dr. Momah in December, although she did not ultimately transfer to him until February (Ex. 5, p. 3). There is simply no logical explanation for such a referral other than the fact that it must have been made because Dr. Momah knew he did not yet have privileges at Canton-Potsdam Hospital. Moreover, the Respondent testified that pending the outcome of his application for privileges, many of his patients wished to continue their prenatal care with him and take a "wait and see" approach regarding privileges (T. 633-34). As Patient B indicated she was pleased with the care she received from Dr. Momah, his testimony would explain why patient B was not eager to transfer to Dr. Garcia and continued to see Dr. Momah, despite having been referred to Dr. Garcia at the first visit(Ex. 5, p. 3).

It is unclear what happened with Patient B. Perhaps she misunderstood Dr. Momah's assertions regarding privileges; perhaps she received incorrect information about his privileges from his staff or mistakenly (but understandably) concluded that because the Respondent opened a Potsdam office, he had been granted privileges; or perhaps the confusion resulted from the fact that Patient B relied solely on her memory both when testifying and when discussing the events with the Department a full two and one half years after they occurred (T. 44, 46). What is known is that Patient B was referred by Dr. Momah to another doctor at her very first visit, and according to at least one other patient of Dr. Momah's, he did not misrepresent his privilege status. The Hearing Committee must conclude that as the burden of proof is on the Petitioner to prove the allegation by a preponderance of the evidence, in light of the conflicting testimony on this point, the Petitioner did not meet its burden and we cannot sustain the allegation.

DETERMINATIONS - PATIENT B

1. Allegation B.1 is not sustained.

FINDINGS OF FACT - PATIENT C

1. Respondent provided medical care to Patient C, a 20 year old female when first seen, from on or about April 4, 1991 through on or about April 10, 1991, at Respondent's office. Patient C presented with what Respondent diagnosed as "extensive vaginal and vulva condyloma." (Exs. 6, 8).

2. Patient C had been evaluated on April 1, 1991 by Planned Parenthood of Northern New York for complaints including abnormal vaginal discharge, and pain during intercourse. The plan of treatment was for application of 85% trichloroacetic acid ("TCA"). This was done by a nurse practitioner of Planned Parenthood on or about April 1, 1991. Patient C experienced a slight burning from that treatment which subsided in about an hour. Patient C was thereafter referred to Respondent for additional treatment (Ex. 6, p. 5; Ex. 8, pp. 5-6).

3. Patient C saw Respondent first on April 4, 1991. Respondent diagnosed multiple small external condylomata, also vaginal and cervical condyloma. He performed a colposcopy, then planned to perform treatment with TCA following receipt of the pathology results (Ex. 6, p. 1).

4. There is nothing in Respondent's record that indicates that the patient had any burns from the earlier application of TCA when she came into the care of Respondent a few days later (Ex. 6, p. 1; T. 341-42).

5. Respondent applied TCA to Patient C's cervix, vagina and vulva on or about April 10, 1991. Respondent used something that felt to the patient like an oversized Q-tip which had been drenched in acid. Dr. Momah applied the acid very quickly, sort of paint brush style, both internally and externally (T. 233-35).

6. After the treatment, Patient C was in such severe pain that she could not move. After a few minutes, she was able to get up and go into the bathroom. After she left, a friend drove her home and she went straight to bed. Within a day or so, she went for medical treatment to Planned Parenthood, since she was in such severe pain, and she was bleeding fairly heavily. In the few days after the treatment, the patient experienced pain and burning, which made it difficult for her to walk and sit. Because of this, she did not rub the area that was treated, and she tried not to even touch the area (T. 241-42).

7. After she received the acid treatment from Respondent, Patient C did not see Respondent again that day (T. 239).

8. Following her treatment by Respondent on April 10, 1991, Patient C. saw the following health care providers for treatment related to her ongoing pain and burns:

April 12 - Contente, M.D. (Ex. 8, p. 9)

April 15- Gaffney, M.D. (Ex. 9, p. 1)

April 17 - Gaffney, M.D. (Ex. 9, p. 2)

April 23 - St. Lawrence University M.D. (Ex. 10, p. 1)

May 1 - Gaffney, M.D. (Ex. 9, . 2)

May 10 - St. Lawrence University M.D. (Ex. 10, p. 1)

May 17 - Planned Parenthood of Northern New York M. D. (Ex. 8, p. 3)

June 24 - Planned Parenthood center of Syracuse, Nurse Practitioner (Ex. 7, p. 5)

9. Records of Patient C's subsequent treatment in April, May and June 1991 vary from one another with respect to the extent and areas of possible burning from the TCA, but all such records indicate the presence of burns around the buttocks and posterior areas. The records make no mention of the presence of burns on Patient C's thighs, knee or back (Exs. 7-10).

10. There is no indication on the record that the patient had genital warts on her buttocks or around the anus and posterior areas. The presence of burns in those areas is not consistent with the appropriate application of TCA (T. 121-28, 346-48).

11. TCA is a powerful caustic substance. It should be applied very carefully, making sure that there is no rundown of excessive TCA, and that the TCA does not pool at any point on the table where the patient's skin comes in contact with it. It should not be applied in an amount exceeding what is needed for treatment (T. 121-28, 345-46).

12. The risks of using TCA include excessive burning (T. 119).

13. The excessive application of TCA by Respondent caused the burns seen by the subsequent treating physicians (T. 344-45).

14. Allegation C.2 was withdrawn by the Petitioner, based on the documentary evidence produced and the testimony of the witnesses.

CONCLUSIONS - PATIENT C

Based on the testimony of Patient C, both expert witnesses, and medical records, the Hearing Committee concludes that the Respondent negligently overtreated Patient C with TCA (T. 121-28, 234, 237, 346-48: Exs 8, p. 3; 7, p. 5; 9, p. 1). The extent to which Patient C was overtreated is not entirely clear from the drawings or narrative in records of the physicians who treated her subsequent to her treatment by Respondent, but all such records indicate the presence of burns in areas in which no condylomata were ever noted. The mere presence of TCA-related burns in areas in which no condylomata were purported to be treated by Respondent; i.e., the buttocks and posterior areas, is

enough to sustain a finding of negligence, because the careful application of TCA would not have resulted in burns in areas which contained no condylomata and thus should not have come in contact with the acid.

Patient C testified straightforwardly and graphically, and was unwavering under direct, cross and panel examination. She said she had scars for over two years from the treatment by Respondent, and that he dripped some acid on her knee. The Hearing Committee finds no mention in medical records of any burns on her knee, and notes that no evidence corroborating Patient C's claim of such long-term scarring was presented. Such findings are inconsequential, however, in light of sufficient evidence supporting a finding of negligence by the Respondent.

DETERMINATIONS - PATIENT C

1. Allegation C.1 is sustained.

FINDINGS OF FACT - PATIENT D

1. Respondent provided medical care to Patient D, a female patient 48 years old when first seen, on or about February 23, 1990 at Massena Memorial Hospital. Patient D was admitted to the Hospital with a complaint of severe right lower quadrant abdominal pain of sudden onset, 12 hour duration (Ex. 11, pp. 92-93).

2. The patient had signs consistent with intra-abdominal infection, which was confirmed by a blood white count which was significantly elevated. The presence of immature white cells; i.e., bands, such as are identified on the lab report, is a sign of acute and significant infection, classically associated with some sort of intra-abdominal or pelvic infectious process (T. 152, 54; Ex. 11, p. 9).

3. On February 23, 1990, the Respondent performed a diagnostic laparoscopy, and a laparotomy with the participation of Dr. Lin. At laparoscopy, approximately 450 cc of serous liquid and a large quantity of pus were found in the lower abdomen and pelvis. At subsequent laparotomy, findings that were classic for an intra-abdominal infectious process were found. There were scar tissue and adhesions between the bowel and pelvic side of the wall. The right lower quadrant in particular was involved, with involvement of the right fallopian tube and ovary, as well as the appendix itself (T. 156; Ex. 11, pp. 165-66).

4. Pus in the abdominal cavity is an abnormal finding. Freestanding pus should never be found in the abdominal or pelvic cavity. Also, adhesions are generally a response to long-standing infection (T. 156).

5. During the course of the procedures, Dr. Momah advised Dr. Lim that the patent needed to have her appendix removed and that Dr. Lim would have to do it because Dr. Momah did not have privileges to do an appendectomy (T. 670-71).

6. Following the performance of the appendectomy, the remainder of the procedure was carried out by Respondent (Ex. 11, pp. 165-67).

7. Dr. Momah performed a primary closure of the skin, which essentially involves closing the various layers of the peritoneum and other internal structures and layers, and working outward (T. 162-64, 672; Ex. 11, pp. 165-66).

8. In the presence of significant peritonitis, the potential for gross contamination of the fat layer and the layers below the skin down to, but not including, the fascia, is substantial; therefore, it is generally considered appropriate to leave the area open for 24 to 48 hours. If at that pont there

is no infection, the skin may then be closed, or left open to heal from the bottom up. (T. 164-65; 360).

9. In such circumstances, the infection rate is increased if a primary closure is performed (T. 362, 366).

10. While many doctors recommend that the skin should be left open, the decision to do so does not constitute a standard of care from which physicians may not deviate; rather, it is a judgment call. While there is an increase in the wound infection rate if a primary closure is performed, there are also some drawbacks to performing a secondary closure (T. 360, 363). The question of which closure is appropriate may even depend upon regional training (T. 175).

11. Patient D. experienced a wound dehiscence; i.e., the abnormal opening up of an incision that has already been closed (Ex. 11, p.99).

12. The Respondent took appropriate, prompt action when he first saw Patient D, who presented in emergent condition, and when her wound eviscerated (T. 361-62; Ex. 12, pp. 277-78; Ex. 11, pp. 92-93).

13. It is a standard hospital practice that at any major surgical procedure, two operating surgeons are necessary (T. 160, 179).

14. Dr. McCullough, a physician who reviewed Patient D's records for quality assurance purposes, stated that "the patient's treatment was appropriate and skillful" and that "the patient's care was commendable with adequate treatment and recognition of a difficult and potential life-threatening infectious process." (Ex. 12, pp. 277-78).

CONCLUSIONS - PATIENT D

Whether the decision to perform a primary closure was made jointly by Dr. Momah and Dr. Lin, or was solely Dr. Momah's, is somewhat unclear from the documentary evidence and testimony. The Respondent testified that the decision to perform a primary closure was made jointly with Dr. Lin. However, Respondent's post-operative notes contain a complete and thorough description of the closure that was performed, while Dr. Lin's post-operative notes following the description of the appendectomy he performed simply state that the remainder of the procedure was carried out by Dr. Momah. The Hearing Committee finds the documentary evidence, consisting of post-operative notes made just after the surgical procedures were performed and containing each physician's detailed description of the procedures carried out by him, to be more reliable than Dr. Momah's testimony alone. There is nothing in Dr. Momah's notes to indicate that the decision was made jointly, nor are there any references to the closure in Dr. Lin's notes. Accordingly, the Hearing Committee concludes that the decision to perform a primary closure was Dr. Momah's.

The Hearing Committee also concludes that the Respondent's decision to perform a primary closure on Patient D did not fall below minimum standards of care and was an appropriate judgment call. No testimony was presented which could articulate a specific standard of care for closures in these circumstances. In fact, both the Petitioner's and Respondent's experts testified that the closure decision may be a function of regional training, and evidence was presented which indicates that in some cases, there may be drawbacks to performing a secondary closure. If there were a true standard to be followed in this case, regional training would have been irrelevant. The mere fact that the wound infection rate is greater when a primary closure is performed does not require that a secondary closure be made; rather, the decision is a judgment that must be made based on the facts of a particular situation.

In this instance, Dr. McCullough's quality assurance review commended Dr. Momah's appropriate and skillful treatment under potentially life threatening conditions, and did not question the closure decision. In addition, Patient D's severe infection at the time the procedures were performed may have caused the wound dehiscence, which was treated promptly and effectively by the Respondent. Finally, even if Dr. Momah was solely responsible for the decision to close primarily, it is clear that two operating surgeons were present during the procedures performed on Patient D. No testimonial or documentary evidence was introduced which would indicate that Dr. Lin ever questioned the decision to perform a primary closure. Surely, if Dr. Lin disagreed with that decision and felt it did not meet the due standard of care, he could have said so, either at the time of the procedure or even during his post-operative notes. Accordingly, The Hearing Committee concludes that that Respondent's decision to perform a primary closure on Patient D was appropriate.

DETERMINATIONS - PATIENT D

1. D.1 is not sustained.

FINDINGS OF FACT - PATIENT E

1. Allegations E.1 and E.3 were withdrawn by the Petitioner, based on the documentary evidence produced and the testimony of the witnesses.

2. Allegation E.2 was withdrawn without presentation of evidence.

FINDINGS OF FACT - PATIENT F

1. Respondent provided medical care to Patient F, a female patient 25 years old when first seen, from on or about February 12, 1990 through March 1990 at Respondent's office and at MMH. Patient F received prenatal and obstetric care from Respondent. (Exs. 17-19).

2. Patient F was seen for an initial prenatal visit on or about February 12, 1990 (Ex. 17, pp. 60-62).

3. Respondent's initial prenatal evaluation of Patient F documents that the patient had class D diabetes in pregnancy. The patient was insulin dependent and had diabetes for approximately 20 years (Ex. 17, pp. 60-62).

4. A patient who has class D diabetes faces certain risks. Such patient may require increasing amounts of insulin during pregnancy and have varying needs for insulin use during pregnancy. The risks to the fetus include hypoglycemia; i.e., low blood sugar, which is associated with a number of significant birth defects and birth problems including mental retardation. The patient may also face hyperglycemia, associated with significant problems with the fetus, especially relating to the size of the fetus and hypertrophy or excessive growth of many organ systems. Accordingly, class D diabetes requires a rather intensive evaluation of the patient initially. (T. 434).

5. Patient F had a fasting blood sugar on initial evaluation of 247. That is considered an abnormal value and is a significant elevation in the blood sugar. The medical significance is that the obstetrician should be immediately concerned that the patient is not well-controlled with her current insulin regimes. Such a patient needs rather intensive control. Even though the period of organ formation and fetal development basically is already completed, and the growth of the fetus is now

an issue, there are always concerns about having tight control. It is a delicate balance that has to be achieved in managing a patient with an elevated blood sugar, but one which needs rather aggressive therapy. (Ex. 17, p. 62; T. 435-36).

6. During Patient F's initial visit, Respondent recognized that she was a high-risk patient and would need to be transferred to a high risk center for management. Respondent discussed with her the risks of her diabetes and her pregnancy (T. 703-04; Ex. 17, pp. 61-62).

7. Dr. Momah commonly referred high-risk patients to a center in Burlington, Vermont (T. 705).

8. Dr. Momah told Patient F that she was going to be transferred to Burlington (T. 705; Ex. 17, p. 61).

9. Dr. Momah assumed that Patient F would not be returning to his office for care and that all of her pregnancy care would be taken care of in Burlington (T. 705-06).

10. Patient F presented at MMH early in the morning of March 12, 1990, complaining of vaginal bleeding. Patient F was near the end of her first trimester with significant vaginal bleeding in the absence of any abdominal pain. The patient had never had a full term pregnancy and was severely diabetic (T. 440, 706-07; Ex. 18, pp. 125-27).

11. At that time, Dr. Momah called Dr. Jhaveri, an internal medicine doctor, in consultation to manage Patient F's diabetes (T. 707).

12. Patient F had indicated to Dr. Momah that Dr. Jhaveri was her doctor. She had been seeing Dr. Perdue, who sold his practice to Dr. Jhaveri, so Dr. Perdue's patients became Dr. Jhaveri's patients (T. 707-08).

13. Family practitioners can handle diabetes and Dr. Momah's referral to Dr. Jhaveri, whom he believed to be Patient F's doctor, was not inappropriate, negligent or incompetent (T. 400, 451, 457, 459).

14. Dr. Momah told Patient F, both while she was in his office and in the Hospital, that she would need to go to the high risk management center in Burlington (T. 705-06, 711; Ex. 17, pp. 23, 24, 61).

15. Patient F did not follow Respondent's instructions to transfer to Burlington. In addition, during Patient F's initial hospitalization, Dr. Momah instructed her to stay for three additional days to obtain control of her diabetes. Patient F, however, left despite this advice (T. 710-11; Ex. 17, p. 24).

16. Dr. Momah made numerous efforts to refer Patient F to a maternal fetal medicine consultant in Burlington (Ex. 17, pp. 23, 24, 61).

17. The Respondent did not document whether he or his staff actually made any appointments for Patient F with a maternal fetal medicine consultant, nor is there any record that any letters of non-compliance were ever sent to Patient F (Ex. 17).

18. While sending letters to non-compliant patients may be wise, the failure to do so does not constitute professional misconduct (T. 472).

19. When the patient was in the MMH emergency room on March 12, 1990, she received 300 micrograms of RhoGAM by order of the Emergency Room Physician (Ex. 18, p. 126). RhoGAM is an immune globulin. It is an antibody that blocks a patient's initial response to the RH antigen. Such antigens can lead to hemolytic disease in the newborn (T. 440-41).

20. Hemolytic disease in the newborn is a condition in which the mother who is RH negative creates antibodies to RH positive red blood cells. It is similar to our own immune response. The mother's RH antibodies can cross the placenta and ultimately destroy the red blood cells in a living intra-uterine fetus. The purpose of RhoGAM is to block this response by preventing the mother from producing antibodies to an RH positive label on the red blood cells (T. 441-42).

21. Patient F had blood work done and an antibody screen which indicates that the patient's blood was B-, also DU-. These lab results were consistent with the initial administration of RhoGAM to the patient in the Emergency Room. The lab slip indicates that the patient was, at that point, not RH sensitized and had no evidence of antibodies in her blood (Ex. 18, p. 68; T. 442-43).

22. Respondent diagnosed the patient as having alloimmunization to the RH factor. This means that Respondent was under the impression that the patient had become sensitized to the RH factor. This was incorrect, as the initial obstetric visit showed that the patient had a negative antibody titer. The in-hospital lab report indicated that the patient had a negative antibody titer, and the only time the patient had a positive antibody titer was after she had received the RhoGAM. (Ex. 17, p 1, p. 62; Ex. 18, p. 3).

23. The Respondent later acknowledged that Patient F should not have received the potency of RhoGAM that she received (T. 709; Ex. 17, p. 1).

24. The Respondent apparently had believed that Patient F had had a fetal maternal transfusion of red blood cells; that is, from the fetus to the maternal blood stream, of greater than fifteen cc's. This would have been the appropriate indication to give a second vial of RhoGAM, or three hundred micrograms, if it could have been verified that the patient was, indeed, a recipient of that excessive dose of fetal red blood cells. The Respondent did not have available to him the standard Kleihauer-Betke test, which gives a quantitative assessment of the degree of fetal red blood cells that have been transfused into the mother (T. 444, 709).

25. The standard of care in relation to the administration of RhoGAM requires that if there is any concern about the need or lack thereof for RhoGAM, the physician should err on the side of giving the RhoGAM (T. 401, 446-47).

26. The Respondent's administration of RhoGAM did not harm Patient F (T. 447, Ex. 18).

37. After Dr. Momah cared for Patient F, he completed a number of continuing medical education courses, including courses on Rh sensitization (T. 596-602; Exs. KK, LL).

CONCLUSIONS - PATIENT F

As to issues surrounding the management of Patient F's diabetes and referrals to specialists, the Hearing Committee concludes that on at least several occasions, the Respondent specifically referred Patient F, who ultimately revealed herself to be a non-compliant patient, to a maternal fetal medicine specialist in Burlington. The Respondent testified that his office even made an appointment for Patient F, however, we find no proof that this occurred. If an appointment were made by Dr. Momah's staff, it should have been documented in the record. Nevertheless, the Respondent's failure to make an appointment for Patient F or to write a letter to the patient regarding the referral or her

level of compliance does not constitute professional misconduct, as even the Petitioner's expert testified.

The Hearing Committee also concludes that the Respondent showed sensible judgment in making a referral to Dr. Jhaveri when Patient F was in the hospital. Responding to Patient F's test results, the Respondent immediately took steps to manage the patient's condition by making the most appropriate referral that was available to him at the time. The patient indicated to Dr. Momah that Dr. Jhaveri was her physician, and in the absence of a local maternal fetal specialist, Dr. Jhaveri, as a family practitioner, should have possessed the requisite skills and training to manage the patient's diabetes, as both experts testified.

As to the issue of the administration of RhoGAM to Patient F, the Hearing Committee finds that the Respondent's actions indicated that he was obviously confused about the patient's condition of sensitization. While Dr. Momah's administration of an additional 300 micrograms of RhoGAM to this patient was arguably correct, particularly absent the availability of the Kleihauer-Betke test, his understanding of the indications for giving RhoGAM could potentially have resulted in serious consequences for patients and fell below the level of knowledge and skill required of a practicing OB/GYN. The Hearing Committee thus concludes that the Respondent exhibited incompetence in this case.

DETERMINATIONS - PATIENT F

1. Allegation F.1 is not sustained.

2. Allegation F.2 is sustained.

3. Allegation F.3 is not sustained.

FINDINGS OF FACT - PATIENT G

1. Respondent provided medical care to Patient G, a female patient 25 years old when first seen, from on or about November 6, 1989 through November 11, 1989 at Respondent's office and at Massena Memorial Hospital. Patient G presented to Respondent's office on November 6, 1989 with a chief complaint of left lower quadrant pain, abrupt onset 3 days prior, and was admitted to MMH (Ex. 21, p. 3).

2. Respondent's history and physical exam of patient G identifies that the patient had an "entirely unremarkable" past medical and surgical history (Ex. 21, p. 4).

3 Respondent also describes the patient's menstrual cycle as being regular, and the patient being not sexually active and not believing she is pregnant (Ex. 21, p. 4).

4. Approximately two years after treating Patient G, Respondent prepared a document for an MMH quality assurance ("QA") review regarding patient G's treatment (Ex. 20, p. 25).

5. The QA document states, "It was known that she had had a previous tubal ligation." (Ex. 20, p. 25).

6. The document also indicates that the patient had a prior cesarean section, but that it had not been apparent since the patient "was in excruciating pain and was a poor historian." (Ex. 20, p. 25).

7. Respondent's QA document also stated that the diagnosis of tubal pregnancy was made based on Patient G's abnormal menstruating pattern (Ex. 20, p. 25).

8. Patient G had scars on her abdomen from the cesarean sections and an appendectomy. (Ex. 21, p. 66).

9. Due to the increasing severity of Patient G's pain, Respondent decided to perform a laparoscopy (T. 724; Ex. 21).

10. Respondent saw and removed what he believed to be a tubal pregnancy (T. 724; Ex. 21).

11. The day after Patient G's surgery, a serum pregnancy test was obtained that showed an HCG level of nine, which Respondent considered to be positive. The level was higher than the laboratory's level of four for a non-pregnant female, but just below the level of ten for a pregnant female in the first week after conception (T. 725-26; Ex. 21, p. 29).

12. Following Patient G's surgery, a surgical specimen was evaluated by the pathology department. The surgical tissue report identified in its final diagnosis a portion of the left fallopian

tube with a benign cyst, a foreign body (plastic clip), and a foreign body reaction; also, a benign follicle cyst from the left ovary (Ex. 21, p. 49).

13. The "clip" was likely a so-called Hulka clip, which is used to perform a tubal ligation (T. 413).

14. The pathology report indicated nothing about there being an ectopic pregnancy (T. 496).

15. Respondent, in preparing his final diagnosis of the cause of Patient G's complaints for her discharge summary, had available to him the pathology report. Respondent's final diagnosis included left unruptured ectopic pregnancy (Ex. 21, p. 3).

16. Respondent did not change the discharge summary to reflect the pathologist's report because he felt the clinical symptoms should override the pathology results (T. 725, 726-27, 737).

CONCLUSIONS - PATIENT G

The evidence clearly shows that there were several significant, unexplained discrepancies between Respondent's documented patient history, Patient G's actual history and Respondent's QA document. For example, Patient G's record, as documented by Respondent, indicated that her medical and surgical histories were "entirely unremarkable," and that she had a regular menstrual cycle. No mention was made in the record of her two previous cesarian sections, her tubal ligation, or her appendectomy, and no scars were identified. The QA report indicated that Patient G's tubal ligation was known at the time of the surgery, yet there is no mention of it in Patient G's record. The QA report also states that Patient G had an abnormal menstrual cycle, contrary to the history recorded by Respondent.

Respondent also testified that he was able to elicit sufficient information from Patient G for a complete history and physical, yet he also indicated both in his testimony and in his QA report that he had to cut the examination short due to Patient G's excruciating pain and that the patient was a poor historian (T. 728-29; Ex. 20, p. 25).

Based on the foregoing, the Hearing Committee concludes that the Respondent clearly did not perform a complete history and physical, yet documented that he did. Even if Dr. Momah's failure to perform the complete history and physical were justified by the emergent circumstances, this should have been documented at the time and not simply explained away during a subsequent Quality Assurance review. The Hearing Committee concludes that the failure to accurately document the history and physical that was actually conducted falls below the required standard of care and constitutes negligence.

As to the issue of the Respondent's discharge summary, the Hearing Committee concludes that Respondent was not negligent in declining to conform his discharge summary to the pathologist's report. The Respondent presented credible testimony as to the basis for his diagnosis of an ectopic pregnancy, including the serum pregnancy test and clinical symptoms, and the Petitioner's own expert witness agreed that the it was appropriate for Dr. Momah to not change the summary in light of his strongly held belief that an ectopic pregnancy had in fact occurred.

DETERMINATIONS - PATIENT G

1. Allegation G. 1 is sustained.

2. Allegation G.2 is not sustained.

FINDINGS OF FACT - PARAGRAPH H

1. Respondent, on or about October 2, 1992, completed his re-registration application which was required to be filed with the New York State Education Department to be licensed as a physician for the period January 1, 1993 through December 31, 1995 (Ex. 2, unnumbered p. 22).

2. Respondent's privileges at MMH had been summarily suspended for failure to provide timely coverage of obstetrical services to the emergency department beginning February 12, 1992, and continuing through February 21, 1992, all of which was after Respondent's last registration. Respondent knew such facts (Ex. 22, T. 283)

3. Following the submission by Respondent of documentation substantiating his unavoidable delay in returning from Nigeria, the suspension was lifted and clinical privileges at MMH were reinstated (Ex. 22).

4. Respondent was under the impression that his attorney and MMH administrators told him to act as though the suspension had never occurred (T. 591-92).

5. Respondent failed to provide details regarding the suspension of his hospital privileges, as required by the re-registration application. He answered "no" in response to Question 1(c) of the application, which read as follows:

> Since you last registered, has any hospital or licensed facility restricted or terminated your professional . . . privileges . . . ?

(Ex. 2, unnumbered p. 22).

CONCLUSIONS - PARAGRAPH H

The Hearing Committee concludes that the documentary evidence and Respondent's own testimony prove that the Respondent was in fact suspended from MMH and that he answered "no" when asked about privilege restrictions on his re-registration application, so we must sustain the allegation. The Respondent explained in his testimony that Hospital administrators indicated to him that the suspension should not have occurred and was a mistake (T. 592). He further testified that Respondent's attorney advised him that when filling out the re-registration application, he should not mention the suspension and should treat it as though it had never occurred, since the Hospital admitted it was a mistake (T. 592). Given the circumstances surrounding the suspension and the restoration of privileges, the Respondent's explanation was credible; however, he presented no evidence to substantiate these claims and so we give little weight to them.

While the Hearing Committee concludes that the Respondent willfully filed a false report, we cannot conclude that the Respondent intended to mislead the licensing agency and thus do not sustain a finding of fraud. Rather, based on the fact that the Hospital lifted the suspension immediately following Dr. Momah's offer of proof of his unavailability and the possibility that Dr. Momah may have unreasonably relied on the advice of others to treat the suspension as though it had never occurred, we find that Respondent wrongly concluded that he could answer "no" on his re-registration application.

DETERMINATIONS - PARAGRAPH H

1. Allegation H is sustained.

VOTES OF THE HEARING COMMITTEE

The Hearing Committee voted unanimously as follows:

FIRST THROUGH THIRD SPECIFICATIONS (FRAUDULENT PRACTICE)

A and A.2 WITHDRAWN

B and B.2 NOT SUSTAINED

H NOT SUSTAINED

FOURTH THROUGH SIXTH SPECIFICATIONS (MORAL UNFITNESS)

A and A.2 WITHDRAWN

B and B.2 NOT SUSTAINED

H NOT SUSTAINED

SEVENTH THROUGH NINTH SPECIFICATIONS (GROSS NEGLIGENCE)

A and A.3 WITHDRAWN

C and C.1 NOT SUSTAINED

D and D.1 NOT SUSTAINED

TENTH THROUGH TWELFTH SPECIFICATIONS (GROSS INCOMPETENCE)

A and A.3 WITHDRAWN

C and C.1 NOT SUSTAINED

D and D.1 NOT SUSTAINED

THIRTEENTH SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION)

A and A.1 WITHDRAWN

A and A.3 WITHDRAWN

B and B.1 NOT SUSTAINED

C and C.1 SUSTAINED

C and C.2 WITHDRAWN

D and D.1 NOT SUSTAINED

E and E.1 WITHDRAWN

E and E.2 WITHDRAWN

E and E.3 WITHDRAWN

F and F.1 NOT SUSTAINED

F and F.2 NOT SUSTAINED

F and F.3 NOT SUSTAINED

G and G.1 SUSTAINED

G and G.2 NOT SUSTAINED

FOURTEENTH SPECIFICATION (INCOMPETENCE ON MORE THAN ONE OCCASION)

A. and A.1	WITHDRAWN
A and A.3	WITHDRAWN
B and B.1	NOT SUSTAINED
C and C.1	NOT SUSTAINED
C and C.2	WITHDRAWN
D and D.1	NOT SUSTAINED
E and E.1	WITHDRAWN
E. and E.2	WITHDRAWN
E. and E.3	WITHDRAWN
F and F.1	NOT SUSTAINED
F and F.2	SUSTAINED
F and F.3	NOT SUSTAINED
G and G.1	NOT SUSTAINED
G and G.2	NOT SUSTAINED

FIFTEENTH SPECIFICATION (WILFULLY MAKING OR FILING A FALSE REPORT)

H	SUSTAINED

CONCLUSIONS OF LAW

The Respondent is charged with fifteen Specifications alleging professional misconduct within the meaning of Education Law Sec. 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee

consulted a memorandum prepared by Henry M. Greenberg, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

As enumerated below, using the above-referenced memorandum as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Petitioner has sustained its burden of proof regarding two of the Specifications and did not prove nine Specifications. Four Specifications were withdrawn by the Petitioner.

1. The First through Third Specifications charge the Respondent with practicing the profession of medicine fraudulently, based upon factual allegations A and A.2 (withdrawn), B and B.2, and H of the Statement of Charges. The Hearing Committee does not sustain these specifications and finds that the Respondent did not practice the profession of medicine fraudulently within the meaning of New York State Education Law § 6530(2) in that he did not intentionally and falsely represent to Patient B that he had privileges at Canton-Potsdam Hospital in Potsdam, New York, nor did he intentionally and falsely represent on his New York State Education Department registration application that his hospital privileges had been suspended.

The Second and Third Specifications are NOT SUSTAINED.

2. The Fourth through Sixth Specifications charge the Respondent with being morally unfit to practice the profession of medicine, based upon factual allegations A and A.2 (withdrawn), B and B.2 and H of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent did not evidence moral unfitness to practice the profession within the meaning of New York State Education Law § 6530(20), in that Respondent did not fraudulently misrepresent

to Patient B that he had hospital privileges, nor did he fraudulently represent on his registration application that his hospital privileges had been suspended.

The Fifth and Sixth Specifications are NOT SUSTAINED

3. The Seventh through Ninth Specifications charge the Respondent with practicing medicine with gross negligence, based upon factual allegations A and A.3 (withdrawn), C and C.1, and D and D.1 of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent's treatment of Patients C and D was not grossly negligent within the meaning of New York State Education Law § 6530 (4) in that it did not fail to conform to the standard of care that would be exercised by a reasonably prudent physician under the same circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Eighth and Ninth Specifications are NOT SUSTAINED.

4. The Tenth through Twelfth Specifications charge the Respondent with practicing medicine with gross incompetence, based upon factual allegations A and A.3 (withdrawn), C and C.1, and D and D.1 of the Statement of Charges. The Hearing Committee does not sustain the allegations and finds that Respondent's treatment of Patients C and D was not grossly incompetent within the meaning of New York State Education Law § 6530 (6) in that it did not constitute an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the Respondent in the practice of medicine.

The Eleventh and Twelfth Specifications are NOT SUSTAINED.

5. The Thirteenth Specification charges the Respondent with practicing with negligence on more than one occasion, based upon factual allegations A and A.1 (withdrawn), A and A.3 (withdrawn), B and B.1, C and C.1, C and C.2, D and D.1, E and E.1 (withdrawn), E and E.2 (withdrawn), E and E.3 (withdrawn), F and F.1, F and F.2, F and F.3, G and G.1, and/or G and G.2.

The Hearing Committee sustains this specification and finds that Respondent's treatment of Patients C and G was negligent within the meaning of New York State Education Law § 6530 (3) in that it did not conform to the standard of care of a reasonably prudent physician under the same circumstances. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Thirteenth Specification is SUSTAINED.

6. The Fourteenth Specification charges the Respondent with practicing with incompetence on more than one occasion, based upon factual allegations A and A.1 (withdrawn), A and A.3 (withdrawn), B and B.1, C and C.1, C and C.2, D and C.1, E and E.1 withdrawn), E and E.2 (withdrawn), E and E.3 (withdrawn), F and F.1, F and F.2, F and F.3, G and G.1, and/or G and G.2. The Hearing Committee does not sustain this specification because it finds that on only one occasion was the Respondent incompetent within the meaning of New York State Education Law § 5630 (5) in that Respondent demonstrated a lack of requisite skill and knowledge.

The Fourteenth Specification is NOT SUSTAINED.

7. The Fifteenth Specification charges the Respondent with wilfully making or filing a false report, based upon factual allegation H. The Hearing Committee sustains this specification and finds that Respondent wilfully filed a false report within the meaning of New York State Education Law § 6530 (21) in that Respondent wilfully represented on his re-registration application to the New York State Education Department that his hospital privileges had not been restricted when in fact they had. In so finding, the Hearing Committee refers to the factual allegations which have been sustained.

The Fifteenth Specification is SUSTAINED.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that the Respondent should be censured and reprimanded. This determination was reached upon due consideration of the full range of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence produced during this hearing did not prove that there was a pattern of fraudulent, morally unfit, negligent or incompetent conduct by the Respondent; rather, it indicated several apparently isolated cases of negligence and incompetence, as well as one instance of filing a false report. The Respondent does not require a period of retraining or supervised practice. Since the time he saw the patients whose care was at issue in this proceeding, the Respondent has taken many continuing education courses on a variety of topics, including management of high-risk pregnancies and Rh sensitization. Additionally, in November of 1993, the Respondent became certified by the American Board of Obstetrics and Gynecology. The Board conducts an extensive review of cases before certifying physicians, and such cases must meet strict national standards. Finally, while Respondent wilfully filed a false report with the New York State Education Department, he did so not with the intention to deceive, but because of his mistaken reliance on the advice of others.

Based on the foregoing, The Hearing Committee concludes that if Dr. Momah were now to return to New York to practice medicine, he would not pose a danger to the citizens of the state.

ORDER

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

1. The Thirteenth and Fifteenth Specifications of professional misconduct are **SUSTAINED**;

2. The Second, Third, Fifth, Sixth, Eighth, Ninth, Eleventh, Twelfth and Fourteenth Specifications are **DISMISSED**;

3. The Respondent is hereby **CENSURED AND REPRIMANDED**; and

4. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or certified or registered mail.

DATED: 3/31 , **1999**

ANDREW J. MERRITT, M.D.
Chairperson

JAMES O. ROBERSON, M.D.
MARY PATRICIA MEAGHER

EXHIBIT
1
5/18/98 TR

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

IN THE MATTER OF CHARLES M. MOMAH, M.D.	NOTICE OF HEARING

TO: CHARLES M. MOMAH, M.D.
C/O Robert H. Iseman, Esq.
Iseman, Cunningham, Reister & Hyde
9 Thurlow Terrace
Albany, New York 12203

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 27th day of May, 1998, at 10:00 in the forenoon of that day at the Hampton Inn, 417 North 7th Street, Liverpool, New York 13088, (315) 457-6600, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and

you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make

findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE AS A PHYSICIAN IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 28, 1998

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

MICHAEL A. HISER
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

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

--X

IN THE MATTER OF CHARLES M. MOMAH, M.D.	: STATEMENT OF CHARGES

--X

CHARLES M. MOMAH, M.D., the Respondent, was authorized to practice medicine in New York State on August 7, 1987 by the issuance of license number 171684 by the New York State Education Department. The Respondent is not currently registered for the practice of medicine. He was last registered for the practice of medicine for the period January 1, 1995 through June 30, 1997 with an office address of P.O. Box 5178, Massena, New York 13662.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the Appendix), a female patient 24 year old when first treated, from on or about July 23, 1992 through on or about March 1993, at Respondent's office at 180 East Orvis Street, Massena, New York 13662 (hereinafter, "the office"). Respondent provided prenatal obstetric care to Patient A. Respondent's care of Patient A did not meet minimum standards of care, in that:

1. Respondent continued to provide prenatal obstetric services to Patient A after December 31, 1992, when Respondent no longer had admitting privileges at any health care facility with appropriate obstetric services.

2. Respondent, with knowledge that he had no admitting privileges at any facility with obstetric services, misrepresented to Patient A that he was in the process of getting privileges at Canton-Potsdam Hospital in Potsdam, New York, and that he would have privileges "any day".

3. Respondent, with knowledge that he had no admitting privileges at any facility capable of providing obstetric services, contacted Patient A on numerous occasions and offered to deliver Patient A's baby at her home, or at Respondent's office.

B. Respondent treated Patient B from on or about December 14, 1992 through on or about February 16, 1993, at Respondent's office. Respondent provided prenatal obstetric care to Patient B. Respondent's care of Patient B did not meet minimum standards of care, in that:

1. Respondent continued to provide prenatal obstetric services to Patient B after December 31, 1992, when Respondent no longer had admitting privileges at any health care facility with appropriate obstetric services.

2. Respondent, with knowledge that he had no admitting privileges at any facility with obstetric services, misrepresented to Patient B that he had privileges at Canton-Potsdam Hospital in Potsdam, New York.

C. Respondent provided medical care to Patient C, a 20 year old female, from on or about April 4, 1991 through on or about April 10, 1991, at Respondent's office. Patient C presented with what Respondent diagnosed as "extensive vaginal

and vulva condyloma". Respondent's care of Patient C did not meet minimum standards of care, in that:

1. Respondent applied excessive trichloroacetic acid to Patient's C cervix, vagina and vulva, thereby causing severe and extensive burns of the patient's perineal and buttocks region, as well as on the patient's knee.

2. Respondent failed to provide Patient C with adequate instructions for perineal care following the trichloracetic treatment.

D. Respondent provided medical care to Patient D, a female patient 48 years old, on or about February 23, 1990 at Massena Memorial Hospital. Patient D was admitted to the hospital with a complaint of severe right lower quadrant abdominal pain of sudden onset, 12 hour duration. The patient underwent a diagnostic laparoscopy and laparotomy. Respondent's care of Patient D did not meet minimum standards of care, in that:

1. Respondent performed a primary closure of the surgical wound, despite having identified that the patient had severe peritonitis and a pelvic abscess, which was contraindicated in light of the extreme contamination of the operative site.

E. Respondent treated Patient E from on or about May 6, 1991 through on or about December 29, 1991 at Respondent's office and at other health care facilities, including Massena Memorial Hospital, Massena, New York. Respondent provided prenatal and obstetric care for Patient E. Respondent's care of Patient E did not meet minimum standards of care, in that:

1. Respondent inappropriately stopped the administration of oxytocin to Patient E on December 24, 1991, despite diagnosing the patient as having pregnancy induced hypertension, decreased fetal movements, bilateral pedal edema, and an inducible cervix.

2. Respondent, despite the presence of thick meconium after artificial rupture of membranes at approximately 1:45 p.m. on December 29, 1991, failed to discontinue the administration of intravenous oxytocin.

3. Respondent, despite evidence of tetanic contractions during the patient's course of labor from approximately 10:00 a.m. to approximately 4:25 p.m., failed to discontinue the administration of intravenous oxytocin.

F. Respondent provided medical care to Patient F, a female patient 25 years old when first seen, from on or about February 15, 1990 through March 1990 at Respondent's office and at Massena Memorial Hospital. Patient F received prenatal and obstetric care from Respondent. Respondent's care of Patient F did not meet minimum standards of care, in that:

1. Respondent failed to adequately respond to and/or manage the patient's elevated serum glucose levels present at her initial evaluation in mid-February, 1990.

2. Respondent, despite having administered or ordered the administration of 300 mcg of Rhogam on or about March 15, 1990, and having diagnosed Patient F as having "RH negative sensitization", inappropriately administered, or ordered the administration of a second 300 mcg dose of Rhogam, which was not medically indicated.

3. Respondent failed to request a maternal fetal medicine consultation, despite the nature of the patient's symptoms.

G. Respondent provided medical care to Patient G, a female

patient 25 years old when first seen, from on or about February 15, 1990 through March 1990 at Respondent's office and at Massena Memorial Hospital. Patient G, who received prenatal obstetric care from Respondent, presented to the Massena Memorial Hospital on November 6, 1989 with a chief complaint of left lower quadrant pain, abrupt onset 3 days before admission. Respondent's care of Patient G did not meet minimum standards of care, in that:

1. Respondent failed to perform and/or record the performance of an adequate history and physical of Patient G upon admission to the hospital, including references to the patient's two past caesarean section deliveries and the performance of a tubal ligation.

2. Respondent failed to adequately assess, and/or record the performance of an adequate assessment, of the etiology of the patient's complaints in his discharge summary.

H. Respondent, on or about October 2, 1992 falsely answered "No" to question 1(c) on his New York State Education Department registration application, which stated: "Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges . . . due to professional misconduct, unprofessional conduct, incompetence or negligence?" In fact, Massena Memorial Hospital had suspended Respondent's privileges to practice medicine at that facility on or about February 13, 1992 for failure to provide timely coverage of obstetrical services to the emergency department.

SPECIFICATIONS OF MISCONDUCT

FIRST THROUGH FOURTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(2) (McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. The facts in Paragraphs A and A.2.
2. The facts in Paragraphs B and B.2.
3. The facts in Paragraph H.

FOURTH THROUGH SIXTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) (McKinney Supp. 1997) by conduct in the practice of medicine which evidences moral unfitness to practice medicine, as alleged in the facts of:

4. The facts in Paragraphs A and A.2.
5. The facts in Paragraphs B and B.2.
6. The facts in Paragraph H.

SEVENTH THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4) (McKinney Supp. 1997) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

7. The facts in Paragraphs A and A.3.
8. The facts in Paragraphs C and C.1.
9. The facts in Paragraphs D and D.1.

TENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6) (McKinney Supp. 1997) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

10. The facts in Paragraphs A and A.3.
11. The facts in Paragraphs C and C.1.
12. The facts in Paragraphs D and D.1.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(3) (McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

13. The facts in Paragraphs A and A.1, A and A.3, B and B.1, C and C.1, C and C.2, D and D.1, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, G and G.1, and/or G and G.2.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(5) (McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

14. The facts in Paragraphs A and A.1, A and A.3, B and B.1, C and C.1, C and C.2, D and D.1, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, G and G.1, and/or G and G.2.

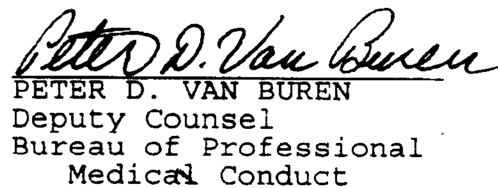
FIFTEENTH SPECIFICATION

WILFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(21) (McKinney Supp. 1997) by wilfully making or filing a false report required by law by the department of health or the education department, as alleged in the facts of the following:

15. The facts in Paragraph H.

DATED: April 28, 1998
Albany, New York



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