NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

December 5, 2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ian Silverman, Esq.
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

Paul E. Walker, PLLC
315 West 106th Street
Suite 1A
New York, New York 10025

RE: In the Matter of Anna Arsenous, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 23-250) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Riverview Center
150 Broadway – Suite 355
Albany, New York 12204

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

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

Sincerely,

[redacted]

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

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

In the Matter of

Anna Arsenous, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 23-250

Before ARB Members Wilson, Rabin, Torrelli, Milone and Reichgott
Administrative Law Judge Jean T. Carney drafted the Determination

For the Department of Health (Petitioner): Ian H. Silverman, Esq.
For the Respondent: Paul E. Walker, Esq.

After a hearing below, a BPMC Committee determined that the Respondent committed professional misconduct by violating minimum acceptable standards of care during two surgical procedures. The Committee voted to impose the penalty of Censure and Reprimand on the Respondent's license to practice medicine in New York State (License). In this proceeding pursuant to New York Public Health Law (PHL) §230-c (4)(a)(McKinney 2019), the Respondent asked the ARB to reverse the Committee's Determination and dismiss the charges. After reviewing the hearing record and the parties' review submissions, the ARB affirms the Committee's Determination.

Committee Determination on the Charges

Pursuant to PHL § 230 *et seq*, BPMC and its Committees function as a duly authorized professional disciplinary agency of the State of New York. The BPMC Committee in this case conducted a hearing on charges that the Respondent violated New York Education Law (EL) §§ 6530(3), 6530(4), 6530(5), 6530(6) and 6530(32) by:

- practicing medicine with negligence on more than one occasion;
- practicing medicine with gross negligence;

- practicing medicine with incompetence on more than one occasion;
- practicing medicine with gross incompetence; and
- failing to maintain a record for each patient which accurately reflects the care and treatment of that patient.

The misconduct occurred in 2013, while the Respondent was practicing at Chenango Memorial Hospital in Norwich, New York. The Department brought nine specifications of charges against the Respondent, relating to her treatment of three patients. The record identified the patients by letters to protect patient privacy. The Committee sustained the seventh specification, that the Respondent committed professional misconduct by practicing with negligence on more than one occasion pertaining to patients A and B. The Committee did not sustain any specifications related to patient C.

The Committee found that while conducting laparoscopic surgery on patient A, the Respondent created an anastomosis between the colon and vagina rather than connecting the colon to the rectum. The Respondent had been assisted by a physician assistant (PA); but she allowed the PA to leave the surgery prior to performing the anastomosis. After the surgery, the patient was discharged from the hospital; but was re-admitted a few days later when she began passing stool through her vagina. Patient A was transferred to a different hospital, and a different surgeon performed corrective surgery.

The Committee determined that while conducting surgery on patient B, the Respondent failed to identify the patient's appendix, failed to identify the tissue she removed while attempting to remove the appendix, and failed to remove the patient's appendix. The Respondent performed a second surgery several days later, successfully removing the appendix and a small bowel obstruction.

The Committee found the Respondent's testimony credible, as was her witness, Dr. Carryl. The Committee also found the Department's witnesses credible. The

Committee noted that the charges pertained to incidents that occurred during five months in 2013, while the Respondent was working at a rural community hospital with systemic problems and limited resources.

The Committee found that the preponderance of the evidence supported sustaining one of the nine specifications brought against the Respondent, and imposed a penalty of Censure and Reprimand.

Review History and Issues

The Committee rendered their Determination on June 9, 2023. This proceeding commenced on June 29, 2023, when the ARB received the Respondent's Notice requesting a review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief, and the Petitioner's reply brief. The record closed when the ARB received the Petitioner's reply brief on July 26. 2023.

The Respondent asked the ARB to overturn the Committee's determination to impose Censure and Reprimand on the Respondent's license. The Respondent argued that the Department failed to meet its burden of proof, and that the evidence did not support the findings or penalty imposed by the Committee.

With respect to patient A, the Respondent pointed to the evidence showing that when the PA had to leave, she had nursing staff contact the Chief Medical Officer, the on-call surgeon, and another surgeon to assist; but was forced to proceed when no one responded. Additionally, the Respondent asserted that the Department's expert, Dr. Zullick, assumed that the Respondent placed the stapler in patient A's vagina. Yet Dr. Zullick had no personal experience with this type of situation, and did not consider a specific medical article on the subject. Regarding patient B, the Respondent contended that there was no evidence supporting the Committee's determination that she deviated from accepted standards of care by failing to identify appropriate anatomic landmarks, and that the tissue she removed was not the appendix.

Finally, the Respondent urged that the allegations be dismissed because the Department waited too long to bring the charges against her. The Respondent argues that imposing a penalty on her license ten years after the incidents occurred serves no legitimate purpose.

The Petitioner replied that the evidence showed the Respondent did not meet minimum standards of care in in her treatment of both patients A and B. Regarding patient A, the Petitioner argued that the Respondent initially blamed her PA leaving the surgery for her incorrectly performing the anastomosis; but ultimately admitted that it was her fault. Additionally, the Petitioner asserts that Dr. Zullick's testimony was consistent with the evidence presented by the Respondent in a medical journal article, as well as the evidence of patient A's medical records. Regarding patient B, the Petitioner asserted that the evidence supports the Committee's determination of misconduct, and the penalty should be upheld.

ARB Authority

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

circumstances, as well as considering the protection of society, rehabilitation and deterrence, *Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).*

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

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

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's determination that the Respondent's conduct constitutes professional misconduct. We affirm the Committee's determination to impose a penalty of Censure and Reprimand.

The ARB agrees with the Committee's assessment of the evidence, including the witnesses' testimonies. The Respondent was responsible for the care and treatment of these patients. The surgery she performed on patient A required an experienced assistant. The Respondent excused the PA assisting her before the surgery was complete, and attached patient A's colon to her vagina instead of her rectum; causing her to pass feces through her vagina, and requiring additional surgery. The Respondent's actions caused harm to her patient, and deviated from accepted medical standards. The Respondent performed laparoscopic surgery on patient B to remove his appendix. However, the tissue she removed was never identified as being part of the appendix, and she had to operate on him again several days later when his condition worsened. The Respondent successfully removed the appendix during the second surgery; but her failure to properly

identify the tissue she removed during the first surgery placed her patient at risk of harm and deviated from acceptable medical standards. The ARB finds that the record provides a rational basis for sustaining the charge of negligence on more than one occasion.

The ARB rejects the Respondent's argument that the Department failed to meet its burden of proof. In addition to the testamentary evidence, documentary evidence supported the Committee's determination to sustain the seventh specification with respect to patients A and B.

Similarly, the ARB finds that the Committee's determination regarding penalty was well reasoned. The fact that the Department waited nearly ten years before commencing this proceeding mitigates against a more restrictive penalty against the Respondent. In addition, there have been no issues with the Respondent's treatment and care of her patients since these incidents occurred; but the fact remains that she committed misconduct. Therefore, the penalty of Censure and Reprimand is appropriate, given the unique facts and circumstances of this matter.

Order

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

1. The ARB affirms the Committee's Determination that the Respondent's conduct constituted professional misconduct.
2. The ARB affirms the Committee's Determination to impose Censure and Reprimand against the Respondent's License.

Linda Prescott Wilson
Jill Rabin, M.D.
Carmela Torrelli
Richard D. Milone, M.D.
Michael J. Reichgott, M.D., PhD.

In the Matter of Anna Arsenous, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Arsenous.

Dated: 27 November 2023, 2023

[redacted]

Linda Prescott Wilson

In the Matter of Anna Arsenous, M.D.

Jill Rabin, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Arsenous.

Dated: November 20th, 2023

[redacted]

Jill Rabin, M.D.

In the Matter of Anna Arsenous, M.D.

Carmela Torrelli, an ARB Member concurs in the Determination and Order in the Matter of Dr. Arsenous.

Dated: Nov 28, 2023

[redacted]

Carmela Torrelli

In the Matter of Anna Arsenous, M.D.

Richard D. Milone, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Arsenous.

Dated: November 1, 2023

[redacted]

Richard D. Milone, M.D.

In the Matter of Anna Arsenous, M.D.

Michael J. Reichgott, M.D., Ph.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Arsenous.

Dated: November 20, 2023

[redacted]

Michael J. Reichgott, M.D., Ph.D.