NEW YORK
STATE OF
OPPORTUNITY.

Department
of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

June 9, 2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ian Silverman, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

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. 23-121) 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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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:

Jean T. Carney, Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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 Judge Carney 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]

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

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

----------X

IN THE MATTER

OF

ANNA ARSENOUS, M.D.

----------X

DETERMINATION

AND

ORDER

BPMC-23-121

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("Department"). A Notice of Hearing ("NOH") and Statement of Charges, and an Amended Statement of Charges, were served on Anna Arsenous, M.D. ("Respondent"). Hearings were held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401. The hearings were held via WebEx videoconference. Jagdish M. Trivedi, M.D. – *Chair* (Chair), Henry Spector, M.D., and Myra M. Nathan duly designated members of the State Board for Professional Medical Conduct ("OPMC" or Board), served as the Hearing Committee ("Committee") in this matter. Kimberly A. O'Brien, Administrative Law Judge ("ALJ"), served as the Administrative Officer. The Department appeared by Ian Silverman, Esq. The Respondent appeared by Paul Walker, Esq. Evidence was received, including witnesses who were sworn or affirmed, and a transcript of this proceeding was made. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing Statement of Charges	September 26, 2022
Answer	October 11, 2022
Pre-Hearing Conference:	October 25, 2022

Hearing Dates:	November 3, 2022
	November 7, 2022
	December 14, 2022
	January 24, 2023
Submission of Briefs	March 6, 2023
Deliberations Dates:	April 18, 2023 & June 2, 2023

STATEMENT OF THE CASE

The Department charged the Respondent with nine specifications of professional misconduct relating to the care and treatment she provided to Patient A, Patient B and Patient C. Pursuant to N.Y. Educ. Law §6530, Respondent was charged with negligence on more than one occasion §6530(3), gross negligence §6530(4), incompetence on more than one occasion §6530(5), gross incompetence §6530(6), and failing to maintain a record that accurately reflects the care and treatment of a patient §6530(32). Exhibit (Ex.) 1.

The Respondent denies all the factual allegations and specifications of charges and offered two affirmative defenses including that"[t]he charges should be dismissed in the interest of justice, and "[a]ll charges should be dismissed as the hearing has been unreasonably delayed." Ex. A. The Department presented four witnesses including Joseph Pisani, P.A.; Mahmood Ahmed, M.D. [1]; Christian Tvetenstrand, M.D.; and Lewis Zullick, M.D. Respondent testified on her own behalf and presented Stephen Carryl, M.D. The Department offered exhibits 1-12, and Respondent offered exhibits A, B, B1, and C-E, all these exhibits were admitted and are part of the hearing record. A transcript of the hearing was made, transcript pages 1-675.

Pursuant to PHL §230(10)(f), the Hearing Committee (Committee) based its conclusions on whether the Department met its burden of establishing that based on the preponderance of the

[1] The record reflects that Dr. Ahmed was not familiar with Patient B's medical record and the care he was receiving at Chenango, for these reasons the Committee did not credit his testimony. Tr. 72-113.

evidence the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (*See* Prince, Richardson on Evidence § 3-206 [Farrell 11th ed]). All the Committee's findings and conclusions are unanimous unless otherwise stated.

FINDINGS OF FACT

The following Findings of Fact (FOF) were made after a review of the entire record in this matter. Citations in brackets, which refer to transcript page numbers (Tr.) and exhibits (Ex.) that were accepted into evidence, and represent evidence found persuasive by the Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Respondent was authorized to practice medicine in New York State on October 18, 1996, by the issuance of license number 204725, by the New York State Education Department. Ex. 2.
2. The charges against Respondent pertain to medical treatment she provided to Patient A, Patient B and Patient C, in 2013 at Chenango Memorial Hospital, a rural community hospital located in Norwich, New York (Chenango). Ex. 1.

Patient A

3. On August 12, 2013, Respondent performed a planned laparoscopic assisted surgery on Patient A, a 45-year-old female. The surgery involved a low anterior resection of the left colon and upper rectum to remove a blocked section of the colon and reconnecting the colon with the rectum (anastomosis). Ex.1, Ex. 3.
4. This surgery requires that a surgeon be assisted by a physician's assistant or another surgeon. Joseph Pisani is an experienced physician's assistant (PA Pisani) and was assigned to assist Respondent with the surgery. Tr. 23, 35-38, 302, 308-309, 311-312, 455-456, 468; Ex. 3, Ex. C.
5. During the surgery PA Pisani fell ill and asked Respondent if he could leave the surgery. Respondent had not yet performed the anastomosis, which requires that an "EEA" (stapler) be introduced into the rectum to staple/connect the colon to the rectum and "this is the only

part where you really need four hands." Tr. 138-139, 169-171, 310-312, 459, 468-469; Ex. 3, Ex. C, Ex. 12.

6. Respondent realized PA Pisani was extremely ill and allowed him to leave and told him to get a replacement and she "immediately" asked the nurses to call the "Chief Medical Officer Dr. Travessani" (CMO), the attending physician and a "colleague surgeon" to replace PA Pisani. Tr. 459, 466; Ex C, Ex. E.

7. Respondent waited "exactly one hour" and when no one came to replace PA Pisani she completed the anastomosis and surgery on her own, and the patient was discharged from the hospital. Tr. 459-464; Ex. 3.

8. On August 17, 2013, a few days after the surgery Patient A was readmitted to the hospital when she began passing stool through her vagina. "The proximal colon was mistakenly anastomosed to the vaginal cuff" (complication). Tr. 136, 145-146, 155-157, 184, 464; Ex. 3, Ex. 12.

9. Upon learning about the complication, Respondent had Patient A transferred to another hospital where a different surgeon completed the colorectal anastomosis. Tr. 464-465; Ex. 3, Ex. 4.

Patient B

10. On or about June 12, 2013, through on or about June 21, 2013, Respondent provided medical care to Patient B, a 52-year-old male. On June 12, 2013, Patient B presented with symptoms of acute appendicitis, and Respondent performed a laparoscopic procedure to remove the appendix. During the surgery Respondent removed tissue and identified it as part of the appendix. A pathology report revealed that the tissue that was removed was not the appendix, and the patient continued to experience symptoms and showed signs of a small bowel obstruction. Tr. 194-198, 202-208, 353-354, 556, 560; Ex. 5, Ex. 12.

11. On June 15, 2013, Respondent performed a second surgery to resolve the small bowel obstruction and removed the appendix. Post-operatively, the patient was having difficulty with his pulmonary status and was placed on a ventilator. The patient was becoming "vent dependent" and Respondent noted in the medical record that "the patient could benefit from use of Precedex" to remove the patient from the ventilator (extubate). On the afternoon of June 21, 2013 Respondent became aware that Precedex "is not available at our hospital and the nursing staff has not been credentialled for the use of the medication" and Patient B was

transferred to "Wilson" a "higher care" hospital where the medication was available and could be administered, the patient was extubated and discharged on June 24, 2013. Tr. 194-195, 232- 233, 238-239, 631-632; Ex. 5 at page 254, 494-496; Ex. 6, Ex. 12.

Patient C

12. Respondent provided medical care to Patient C, a 45-year-old female in October of 2013. Respondent obtained written consent from Patient C to perform a planned laparoscopic cholecystectomy and if necessary, a "possible open cholecystectomy." On October 9, 2013, Respondent began the planned laparoscopic cholecystectomy on Patient C and when she encountered unexpected abnormalities in the anatomy abandoned the procedure. Ex. 7 at page 3, 16, 17, 22, 44, 46; Tr. 438-444.

13. Respondent referred Patient C to Dr. Tvetenstrand. On October 23, 2013, he performed a laparoscopic "top down/dome down" cholecystectomy (dome down cholecystectomy) at "Binghamton" hospital and removed the gallbladder. Tr. 279-286, 441, 444-450; Ex. 8, Ex. 9.

DISCUSSION & CONCLUSIONS

The Hearing Committee (Committee) found the testimony of the Department's fact witnesses PA Pisani and Dr. Tvetestrand to be credible. The Committee found the Department's expert witness Dr. Zullick was qualified by training and experience to provide an opinion about whether Respondent met minimum acceptable standards of care expected of a surgeon working in a similar setting and with a similar patient population during the period the care and treatment was provided and that his testimony was credible.

The Committee found Respondent's witness Dr. Carryl credibly testified about why he believes Respondent is a capable surgeon. Until recently Dr. Carryl was the Chairman of Surgery at Wyckoff Heights Medical Center, a teaching hospital located in Brooklyn, New York (Wyckoff). Respondent began working at Wyckoff in or about 2014 and Dr. Carryl was Respondent's direct supervisor for approximately six years. The Committee noted that Wyckoff is not a rural community hospital, and that Dr. Carryl's observations of Respondent's performance at Wyckoff do not constitute a competency evaluation of the care Respondent provided at Chenango in 2013.

Clearly Respondent has a great deal at stake in the outcome of these proceedings. The Committee found Respondent to be a conscientious physician who showed concern for and followed up with Patient A, Patient B and Patient C, and that her testimony about the allegations against her was credible.

PATIENT A

PA Pisani testified that in 2013 he had thirteen years of experience as a PA and had been assisting at Chenango in all types of surgeries. He was assigned to assist Respondent with Patient A's surgery "a few days or maybe a week before." Tr. 37. PA Pisani's role as an assistant is to provide "another pair of hands..." Tr. 38. He recalled asking how long the surgery was expected to take because he had a young child and "he knew he would have to leave at some point," and that when the surgery went on longer than expected he asked Respondent if he could leave the surgery. Tr. 40-41. PA Pisani did not recall that in his April 2015 interview with the Department he stated the reason he requested to leave the surgery was because he was feeling "fatigued" because he had been on his feet for hours and had not eaten but he does not deny that this is what he told the Department in 2015. Tr. 59-60.

Dr. Zullick testified that this surgery requires the help of an experienced assistant and that it is difficult to perform the anastomosis without assistance. Tr. 168-169. Given that PA Pisani fell ill and that he was not replaced, Respondent had to proceed with completing the anastomosis and the surgery on her own. Tr. 168-169, 182. To perform the colorectal anastomosis a stapler must be placed in the rectum, and Dr. Zulick believed that the complication occurred because Respondent placed the stapler through the vagina and not the rectum. Tr. 154-157. On cross examination, Mr. Walker drew Dr. Zullick's attention to three articles that explain how this complication can occur when the stapler is placed into the rectum and is "angled too far anteriorly." Tr. 170. Dr. Zullick testified that he did not "review the literature regarding the incidents of that complication" but he could "visualize how that complication might happen even when the stapler is placed in the rectum," and agreed that once the complication was recognized it was corrected. Tr. 170-178, 193.

Dr. Carryl testified that PA Pisani was an experienced assistant and more than capable to assist Respondent with the surgery, but it did not matter because he was not there to assist Respondent with the anastomosis. Dr. Carryl agrees with Dr. Zullick that Respondent had to let

PA Pisani leave the surgery and that under the circumstances Respondent was forced to complete the procedure without assistance. Tr. 310-312. Dr. Carryl has performed this type of surgery and testified that the "op report" provides that the Respondent introduced the stapler "transrectally" after "dilation of the rectum with a 28-millimeter lubricated dilator in multiple passes." Tr. 307-308. Dr. Carryl reviewed the literature and explained how the complication can occur when the stapler, which is a "curved instrument," is placed in the rectum and if the "angle is not appropriate," the stapler can "incorporate the vaginal cuff." Tr. 308-310, 333-334. The complication is not the outcome that was sought but it was corrected. Tr. 311-312.

Respondent testified that in the year prior to coming to Chenango she had performed at least "10, 12 twelve of these surgeries." Tr. 493. This was a planned surgery that requires an assistant and Respondent discussed "the preparation of this case" with the CMO, who is a colorectal surgeon, and she believes the CMO assigned PA Pisani to assist her with the surgery. Tr. 455. During the surgery a nurse approached Respondent and said PA Pisani was not feeling well and PA Pisani then explained he was not feeling well and requested to leave. Respondent had "done the bowel transection" but had not yet performed the anastomosis and she explained to PA Pisani that if he could continue for another "20 minutes" she could complete the anastomosis, but PA Pisani was "extremely ill" and she realized she had to let him go and asked him to get a replacement. Tr. 458-459. She "immediately" asked the nurses to call the CMO, the attending physician and a colleague, which they did. Tr. 459-460. Respondent waited "one hour" and "no one answered the calls, and no one showed up" and she had no choice but to go forward with performing the anastomosis and completing the surgery without an assistant. Tr. 466. Respondent documented in the patient record that after she dilated the rectum, she introduced the stapler "transrectally" to perform the anastomosis. Tr. 457-458. When Respondent became aware that the patient was readmitted to Chenango and aware of the complication, Respondent talked with the patient and arranged for the patient to be transferred to another hospital, and for another surgeon to perform a second surgery to correct the anastomosis. Respondent thinks about the circumstances of this surgery "almost every day" and how "they failed me and my patient in that situation" Tr. 463-464. Respondent has "never heard of a surgeon being left alone to operate on a low anterior resection alone and asking for the on-call surgeon for the chief of surgery that was a colorectal surgeon for the colleague not showing up. I've never heard of it, and I should have left the hospital the day after, but I didn't know any better." Tr. 632-633.

The Committee's Conclusions Regarding Factual Allegations A1-A3

The Committee did not sustain factual allegation A.1 and A.2 and sustained factual allegation A.3. The Department alleged that the Respondent is guilty of misconduct because she should not have begun the procedure "with only a physician's assistant, who had no familiarity with the procedure or the patient." Ex. 1 at A1. The record reflects that PA Pisani was an experienced assistant, that this was a planned procedure and that days before the surgery PA Pisani was assigned to assist Respondent. The Committee noted that PA Pisani's testimony about why he requested to leave the surgery varied from his 2015 report to the Department. However, the Committee found that given the passage of time it was understandable his memory had faded. Regardless, the reason PA Pisani requested to leave the surgery has no bearing on his experience/competence. Accordingly, the Committee did not sustain factual allegation A.1.

The Department alleged that Respondent is guilty of misconduct because she should not have "proceeded to perform the anastomosis on her own." Ex. 1 at A 2. The record reflects that the Respondent initiated attempts to replace PA Pisani. It is undisputed that after an hour when no replacement arrived Respondent had little choice but to perform the anastomosis and complete the surgery on her own. Accordingly, the Committee did not sustain factual allegation A.2.

The Department alleged that the Respondent is guilty of misconduct because during the surgery instead of creating an anastomosis between the colon and rectum she "created an anastomosis between the patient's colon and vagina." Ex. 1 at A.3. The record reflects that an unintended connection was made between the colon and the vagina. Accordingly, the Committee sustained factual allegation A.3.

TESTIMONY REGARDING PATIENT B

Dr. Zullick testified that the patient presented with symptoms of acute appendicitis and a laparoscopic appendectomy was indicated. During the procedure the appendix, which is a source of the infection, is removed. Tr. 196-198. When the tissue is removed it can be visually examined "you look at it, and you might even section it, meaning cut it with a knife, to see if you're observing the type of tissue that you would typically see with an appendix, and that's

usually conclusive." Tr. 205-206. The pathology report revealed that the tissue Respondent removed during the procedure was not the appendix. Mr. Silverman asked Dr. Zullick if Respondent had converted to an open procedure, would the appendix likely have been found? Dr. Zullick testified that "converting to an open procedure is not easy thing to do," and "I would not say that converting to an open procedure would in any way guarantee that you are going to be able to successfully identify the appendix." Tr. 208. Dr. Zullick testified that the patient began showing signs of a small bowel obstruction, which is not uncommon, and it was appropriate for Respondent to operate a second time to address it and take the appendix. Tr. 211-213. He is not familiar with the medication Precedex but does not dispute that it could help with weaning the patient off the ventilator and that it was appropriate to transfer the patient when it was determined that the medication was not available and could not be administered at Chenango and was available and could be administered at Wilson, and that the record reflects the patient was transferred, extubated and discharged within a few days. Tr. 238-239.

Dr. Carryl testified that he agrees with Dr. Zullick that Respondent should not have converted the June 12 surgery to an open procedure, and that on June 15 it was appropriate for Respondent to perform a second surgery to address the "small bowel obstruction" and to take the appendix. Tr. 349-354. The medical record reflects that Respondent was closely monitoring the patient and consulting with specialists. Tr. 369. Dr. Caryll testified that Precedex is a sedative that is routinely used to assist a patient who is being weaned off a ventilator, and it was appropriate to transfer the patient when it became clear that Chenango did not have the medication and could not administer it, and Wilson did have it and could administer it. Tr. 369-372.

Respondent testified that the patient was very ill, and she ordered a CT scan that revealed signs of acute appendicitis and she performed a laparoscopic procedure "for better visualization" but if she ran into "bleeding" she would "need to convert to open to complete the surgery." Tr. 509-510. The protocol developed by the "American College of Surgeons" requires "that in an appendicitis case the abscess should be drained first and foremost." Tr. 513. She found "a tissue immediately on the cecum where the appendix would be" and removed it. Tr. 511. Respondent noted that the piece of tissue was "too small" to be the entire appendix and noted in the medical record that it was a "remnant" of the appendix, and she visually inspected the "remnant," which was "tubular and consistent with what the appendix looks like." Tr. 511-512, 561. Respondent

was closely monitoring the patient because "it is very common that when you have appendiceal abscess and peritonitis of this magnitude, the small bowel will stop functioning," and a CT scan "confirmed that this was what was going on." Tr. 521. Respondent operated on the patient to remove the bowel obstruction and saw the appendix and removed it. Tr. 522-524. Post operatively she "called for vent management" and the patient was intubated. Tr. 525-526. Respondent noted that patient's bowel function was improving and the chest x-ray showed a "stable chest," and she consulted with a "critical care specialist at Mount Sinai" who supported her impression that it was time "to attempt to wean the patient of the ventilator." Tr. 537-552. However, the patient was having difficulty being extubated and Respondent noted in the medical record that Precedex should be used to extubate the patient. On the afternoon of June 21, 2013, she learned that Chenango did not carry the medication and the nurses had no experience administering it, and that Wilson had Precedex and could administer it and she agreed to transfer the patient to Wilson where the patient was extubated and discharged on June 24, 2013. Tr. 584-587, 618- 625.

The Committee's Conclusions Regarding Factual Allegations B1-B4

The Committee sustained factual allegation B.1 in part, B.2, and B.3, and did not sustain factual allegation B.4. The Department alleged that the Respondent is guilty of misconduct because she "failed to identify the appropriate anatomic landmarks during the laparoscopic surgery on June 12, 2013 and failed to convert the procedure to an open procedure, despite medical indications." Ex 1 at B.1. The record reflects that Respondent failed to identify the appendix but there was not enough evidence to support converting the procedure to an open procedure. Accordingly, the Committee sustained only the first part of factual allegation B.1, Respondent failed to identify appropriate anatomic landmarks during the surgery.

The Department alleged that Respondent is guilty of misconduct because she misidentified the tissue she removed from the patient as the appendix. Ex 1 at B.2. The record reflects that the Respondent should have been able to visually identify the tissue she removed on June 12 was not the appendix and that she removed the appendix during the second surgery on June 15. Accordingly, the Committee sustained factual allegation B.2.

The Department alleged that the Respondent is guilty of misconduct because during the June 12 surgery she failed to remove the patient's appendix. Ex 1 at B.3. The record reflects that

the Respondent did not remove the appendix on June 12 and removed it during a second surgery on June 15. Accordingly, the Committee sustained factual allegation B.3.

The Department alleged that the Respondent is guilty of misconduct because "following the two surgeries of June 12 and June 15, 2013, failed to transfer the patient for further care at a higher-level facility prior to June 21, 2013, despite medical indications that included the patient's continuing abdominal pain and difficulty breathing." Ex. 1 at B.4. The record reflects that the Respondent was closely monitoring and managing the patient's care during his stay at Chenango, and that on the afternoon of June 21 she was made aware that Chenango did not have Precedex and the staff were not trained to use it, and that Wilson had Precedex and could administer it and she agreed the patient should be transferred to Wilson, where he was extubated and discharged a few days later. Accordingly, the Committee did not sustain factual allegation B.4.

TESTIMONY REGARDING PATIENT C

Dr. Zullick testified that it would not be "appropriate" for a surgeon "to go into surgery" with an agreement that if there was an "intraoperative complication" that calls for an open procedure that it would not be done. Tr. 260. The consent "as signed" by Patient C provides that an open procedure could be performed if necessary. Tr. 261. If a surgeon encounters anatomy that they are uncomfortable with at the beginning of a laparoscopic procedure it is appropriate to abandon the procedure rather than continuing and putting the patient at risk. Tr. 263.

Dr. Tvetenstrand testified that he discussed Patient C's case with Respondent, and he believes it was appropriate for Respondent to abandon the procedure when she encountered something she was not "comfortable with" and did not want to take the risk to move forward and harm the patient. Tr. 286-287. He performed a dome down cholecystectomy on the patient, which admittedly is not the standard technique used by most surgeons, but it is "safer" and "cuts down the risks of common bile duct injuries, injuries in the hepatic artery, which could be, you know life-changing for the patient." Tr. 285. "[T]here is a learning curve to doing it" and most surgeons are not trained how to use the "dome down" technique despite its effectiveness, and he has been advocating on a national level for this procedure to become the "standard." Tr. 286.

Dr. Carryl testified that the patient provided informed consent including that the patient understood that Respondent would convert to an open procedure if a complication arose. Tr. 410. Dr. Carryl agrees with Dr. Zullick and Dr. Tvetenstrand that "any surgeon who is doing the

procedure" if they encounter anatomy that they are not comfortable with it is appropriate to abandon the procedure, the decision is based on "their judgement, based on their experience, and it really cannot be based on what somebody else might think is okay." Tr. 419-420.

Respondent testified that she discussed the procedure, which was elective, with the patient and her husband. Patient C was morbidly obese and had been a "chronic smoker, 30 years, one pack a day" and she had a brother who was also obese and a smoker and "he underwent abdominal surgery the year before and he was promised a laparoscopic surgery, but unfortunately, during the case, it had to be converted to open, and he had a very prolonged complex case, being intubated and eventually became disabled and wheelchair ridden, and she did not want that to happen to her." Tr. 437- 438. Respondent had performed approximately 30 of these surgeries the year before but told the patient that under the circumstances she might be better off going to a "specialized center," the patient refused and wanted Respondent to perform the laparoscopic surgery. Tr. 437. Respondent testified that she "never had an agreement that if something happens, no matter what, I was not going to convert to open." Tr. 439. Respondent agreed to perform the elective laparoscopic procedure to remove the gallbladder and that she would not convert to an open procedure unless she had to do so to "save her life." Tr. 439. Respondent began the procedure, she encountered a "very large liver" and the "cystic duct appeared extremely short" and she needed to delineate "where the cystic duct attaches to the gallbladder," and for about 40 to 45 minutes she attempted to "see an outline of where the cystic and common duct are, because an injury to those would have really devastated this lady," and when Respondent could not see the outline she abandoned the procedure. Tr. 440. Post-operatively, Respondent called Dr. Tvetenstrand and discussed the patient's anatomy, and he laparoscopically performed the "dome down procedure" on the patient, which is not the procedure that she performed, and without complication the gallbladder was removed. Tr. 441-442.

The Committee's Conclusions Regarding Factual Allegations C1-C5

The Committee did not sustain any of the factual allegations pertaining to Patient C. The Department alleged that the Respondent is guilty of misconduct because she "undertook to perform a laparoscopic cholecystectomy despite what Respondent described as the patient's 'refusal' to consent to an open laparotomy, if necessary," that the Respondent had "an informal

agreement with the patient to only perform a laparoscopic procedure," and that the Respondent failed to document the "informal agreement" in the patient's medical record. Ex. 1 at C.1, C.2, C. 5. The record reflects that the patient executed a consent form agreeing to have an open procedure if medically necessary, and that there was no "informal agreement" that Respondent would not perform an open procedure if medically necessary. Accordingly, the Committee did not sustain factual allegation C.1, C. 2, C.5.

The Department acknowledges that Respondent obtained "documented consent" from the patient to perform both a laparoscopic cholecystectomy and a "possible open cholecystectomy," and alleges that Respondent is guilty of misconduct because she "failed to perform the consented to open cholecystectomy, despite medical indications." Ex. 1 at C.3. The record reflects that this was an elective laparoscopic surgery and Respondent did not move forward with the surgery because she encountered anatomical abnormalities and that there were no medical indications for Respondent to perform an open cholecystectomy. Accordingly, the Committee did not sustain factual allegation C.3.

The Department alleges that the Respondent is guilty of misconduct because she "was unable to perform the laparoscopically assisted cholecystectomy despite no apparent anatomical abnormalities being present" which required the patient to undergo a "second laparoscopic procedure by a second surgeon on or about October 23, 2023." Ex. 1 at C.4. The record reflects that Respondent identified anatomical abnormalities during the procedure and that if she proceeded, she may have put the patient at risk and that under the circumstances it was appropriate to abandon the procedure, and that the second laparoscopic procedure performed by Dr. Tvetenstrand was a different procedure/approach where the anatomical abnormalities encountered by Respondent would not necessarily be encountered by Dr. Tvetenstrand. Accordingly, the Committee did not sustain factual allegation C.4.

SPECIFCIATIONS OF MISCONDUCT ONE THROUGH NINE

After due and careful consideration of the entire record the Committee determined that the Department has proven by a preponderance of the evidence that Respondent is guilty of professional misconduct having failed to meet acceptable standards of care in the treatment of Patient A and Patient B. The Committee sustained specification seven, negligence on more than

one occasion as it relates to the treatment of Patient A and Patient B. The Committee did not sustain any of the factual allegations pertaining to Patient C, and accordingly did not sustain any of the charges related to Patient C.

First – Third Specifications

The Department alleged in its first through third specification of misconduct that Respondent practiced the profession of medicine with gross negligence as it relates to Patient A, Patient B and Patient C. Ex. 1. Gross negligence is defined as "negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient." ALJ Ex. 2.

Regarding Patient A the Committee found that Respondent was negligent but there were extenuating circumstances that were out of Respondent's control that required her to complete the surgery on her own and that the complication was corrected, and for these reasons the deviation from the acceptable standard of care was not egregious. Accordingly, the Committee did not sustain the first specification of misconduct.

Regarding Patient B the Committee found that during the surgery on June 12 Respondent's failure to identify the appendix and recognize upon visual inspection that the tissue she removed was not the appendix and failure to remove the appendix constitute negligence, but that the deviations from the acceptable standard of care were not egregious. Accordingly, the Committee did not sustain the second specification of misconduct.

The Committee did not sustain any of the factual allegations pertaining to Patient C, and accordingly did not sustain the third specification of misconduct.

Fourth – Sixth Specifications

The Department alleged in its fourth through sixth specifications of misconduct that Respondent practiced the profession of medicine with gross incompetence as it relates to Patient A, Patient B and Patient C. Ex. 1. For the Committee to sustain a charge of gross incompetence, the Department was required to show that Respondent lacked the requisite skill, knowledge and training to practice, and that the incompetence can be characterized as significant or serious and has potentially grave consequences. ALJ Ex. 2. The Department's own expert, Dr. Zullick, found that it "appeared that Respondent did an appropriate workup," and that surgery was indicated for

each of these patients. Ex. 12. Dr. Zullick stated in his report that the "undesired outcomes" are "not necessarily due to a lack of competence" on the Respondent's part, and that if she had a "qualified surgeon as a first assistant," which is "a standard if not common approach" in every phase of a surgeon's career, these complications may have been avoided. Ex. 12. The record reflects that Respondent was authorized to practice medicine in 1996 and has no reported incidents of misconduct before or after the 2013 incidents at Chenango, that while working at Chenango in 2013 she encountered staffing and systemic issues/problems, and that she had the requisite skill knowledge and training to provide medical care to these patients. Accordingly, the Committee did not sustain the fourth through sixth specifications of misconduct.

Seventh Specification

The Department alleged in its seventh specification of misconduct that Respondent practiced the profession of medicine with negligence on more than one occasion as it relates to Patient A, Patient B and Patient C. Ex. 1. Negligence is defined as "the failure to exercise the care that would be exercised by another physician" and a "deviation from acceptable medical standards in the treatment of a patient." ALJ Ex. 2. The Committee found that Respondent deviated from acceptable standards of care and was negligent in the treatment of Patient A and Patient B. *See* Discussion & Conclusions, First–Third Specifications. Accordingly, the Committee sustained the seventh specification of misconduct.

Eighth Specification

The Department alleged in its eighth specification of misconduct that Respondent practiced the profession of medicine with incompetence on more than one occasion as it relates to Patient A, Patient B and Patient C. Ex. 1. For the Committee to sustain a charge of incompetence, the Department would need to show that Respondent lacked the requisite skill, knowledge and training in her treatment of more than one of these patients. The Committee found that Respondent possessed the requisite skill, knowledge and training to treat Patient A, Patient B and Patient C. *See* Discussion & Conclusions, Fourth–Sixth Specifications. Accordingly, the Committee did not sustain the eighth specification of misconduct.

Ninth Specification

The Department alleged in its ninth specification of misconduct that Respondent failed to "maintain a record for each patient that accurately reflects the evaluation and treatment" for Patient C [Ex. 1]. The Committee did not sustain any of the factual allegations pertaining to Patient C and accordingly did not sustain the ninth specification of misconduct.

PENALTY

The Committee sustained one charge of misconduct, negligence on more than one occasion. The Department requested that Respondent be subject to a three-year probation. The Respondent requested that the charges be dismissed "in the interest of justice" and that the charges be dismissed because the hearing has been "unreasonably delayed."

The Committee noted that the alleged incidents occurred within a five-month period in 2013 while Respondent was working at a rural community hospital with systemic problems and limited resources. The Committee could not ignore that nearly ten years have passed since the misconduct occurred, that Respondent has not had any other reported incidents of misconduct before or after the 2013 incidents at Chenango. In addition, since on or about 2014 Respondent has been working at Wyckoff, and for many years Dr. Carryl supervised Respondent at Wyckoff and he is confident in her abilities.

The Committee found that putting Respondent on probation now serves no purpose. The Committee also found that the Department's delay in bringing the charges forward does not negate the fact that Respondent is guilty of misconduct. The Committee, having fully considered the record and the spectrum of penalties available, has determined that censure and reprimand is the appropriate penalty.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The seventh specification of professional misconduct as it relates to Patient A and Patient B is SUSTAINED.

2. The penalty of censure and reprimand is imposed upon Respondent; and

3. This Determination and Order shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: 6/7/23, New York

[redacted]

JAGDISH M. TRIVEDI - CHAIR
HENRY SPECTOR, M.D.
MYRA M. NATHAN, Ph.D.

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

IN THE MATTER OF ANNA ARSENOUS, M.D.	STATEMENT OF CHARGES

ANNA ARSENOUS, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 18, 1996, by the issuance of license number 204725 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified only in the attached confidential index), a 45-year-old female at various times at the Chenango Memorial Hospital (hereafter "Chenango Memorial") in 2013. Patient A underwent a planned laparoscopic assisted low anterior resection of the left colon and upper rectum by Respondent on or about August 12, 2013, at Chenango Memorial. Respondent's care and treatment of Patient A failed to meet accepted standards, in that:

1. Respondent, during the procedure of August 12, 2013, undertook to perform the procedure with only a physician's assistant, who had no familiarity with the procedure or patient.
2. Respondent, proceeded to perform the anastomosis on her own.
3. Respondent, during the attempted performance of the resection of the colon and rectum, instead created an anastomosis between the patient's colon and vagina.

B. Respondent provided medical care to patient B a 52-year-old male, at various times at Chenango Memorial in 2013. Patient B underwent a laparoscopic appendectomy on June 12, 2013, as performed by Respondent. Thereafter, following additional abdominal pain, Patient B underwent an exploratory laparotomy and planned appendectomy on or about June 15, 2013, as performed by Respondent. Respondent's care and treatment of Patient B failed to meet accepted standards, in that:

1. Respondent, failed to identify the appropriate anatomic landmarks during the laparoscopic surgery of June 12, 2013, and failed to convert the procedure to an open procedure, despite medical indications.
2. Respondent, during the procedure of June 12, 2013, removed an anatomic structure from Patient B that she identified as the patient's appendix. The pathology report indicated that the tissue was not, in fact, the appendix.
3. Respondent failed to remove the patient's appendix during the procedure of June 12, 2013.
4. Respondent, following the two surgeries of June 12 and June 15, 2013, failed to transfer the patient for further care at a higher-level facility prior to June 21, 2013, despite medical indications that included the patient's continuing abdominal pain and difficulty breathing.

C. Respondent provided medical care to Patient C a 45-year-old female, at various times at Chenango Memorial in 2013. Patient C underwent a laparoscopy for a planned cholecystectomy by Respondent on or about October 9, 2013, at Chenango Memorial. Respondent's care and treatment of Patient C failed to meet accepted standards, in that:

1. Respondent undertook to perform the laparoscopic cholecystectomy despite what Respondent later described as the patient's "refusal" to consent to an open laparotomy procedure if necessary.
2. Respondent, despite obtaining documented consent from the patient to perform both a laparoscopic cholecystectomy and a "possible open cholecystectomy", also had an informal "agreement" with the patient to only perform a laparoscopic procedure. Respondent failed to document any such agreement.
3. Respondent, despite obtaining documented consent from the patient to perform both a laparoscopic cholecystectomy and a "possible open cholecystectomy", failed to perform the consented to "open cholecystectomy", despite medical indications.
4. Respondent, was unable to perform the laparoscopically assisted cholecystectomy despite no apparent anatomical abnormalities being present, therefore requiring a second laparoscopic procedure by a second surgeon on or about October 23, 2013.
5. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in paragraphs A and A1, A and A2, and/or A and A3

2. The facts in paragraphs B and B1, B and B2, B and B3, and/or B and B4.

3. The facts in paragraphs C and C1, C and C2, C and C3, and/or C and C4.

FOURTH THROUGH SIXTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. The facts in paragraphs A and A1, A and A2, and/or A and A3.

5. The facts in paragraphs B and B1, B and B2, B and B3, and/or B and B4.

6. The facts in paragraphs C and C1, C and C2, C and C3 and/or C and C4.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

7. A and A1, A and A2, A and A3, B and B1, B and B2, B and B3, B and B4, C and C1, C and C2, C and C3, and/or C and C4.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

8. The facts in paragraphs A and A1, A and A2, A and A3, B and B1, B and B2, B and B3, B and B4, C and C1, C and C2, C and C3, and/or C and C4.

NINTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

9. The facts in paragraphs C and C2, and/or C and C5.

DATE: September 26, 2022
Albany, New York

[redacted]

JEFFREY J. CONKLIN
Deputy Director
Bureau of Professional Medical Conduct