



STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 16, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Naji Abumrad, M.D.
5 Dodge Lane
East Setauket, New York 11733

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Charles L. Bach, Jr., Esq.
Heidell, Pittoni, Murphy & Bach, P.C.
99 Park Avenue
New York, New York 10016

RE: In the Matter of Naji Abumrad, M.D.

Dear Dr. Abumrad, Ms. Abeloff and Mr. Bach:

Enclosed please find the Determination and Order (No.97-175) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Tyrone T. Butler". The signature is written in a cursive style with a large initial "T" and "B".

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

COPY

STATE OF NEW YORK : DEPARTMENT OF HEALTH (Petitioner)

IN THE MATTER

OF

NAJI ABUMRAD, M.D. (Respondent)

Proceeding to review a Determination by a Hearing Committee
(Committee) from Board for Professional Medical Conduct (BPMC)

ADMINISTRATIVE
REVIEW BOARD
(Board)
DETERMINATION
AND ORDER
ARB 97-175

Before: **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D. and WILLIAM A. STEWART, M.D., Board Members.**

After a hearing into charges that the Respondent, a surgeon, committed professional misconduct, a BPMC Committee sustained charges that the Respondent practiced with negligence or incompetence on more than one occasion, in treating five patients. As a Penalty, the Committee suspended the Respondent's License, stayed the suspension and placed the Respondent on probation for one year. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c(4)(a)(McKinney's Supp 1997), the Petitioner asks the Board to increase the Committee's Penalty to three years stayed suspension and three years probation. The Respondent requests that the Board vacate the Committee's Determination. After considering the hearing record and the parties' briefs, the Board sustains in part and modifies in part the Committee's Determination that the Respondent practiced with negligence on more than one occasion and we overturn the Determination that the Respondent practiced with incompetence. We sustain the Penalty suspending the Respondent's License, staying the suspension and placing the Respondent on one year's probation, but we modify the Probation Terms. We conclude that the Respondent's conduct, in treating the patients at issue in this case, demonstrated a careless practice pattern, that warrants a formal probation period, to assure that the Respondent has corrected his practice deficiencies.

Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer and drafted this Determination. **CHARLES L. BACH, JR., JANICE K. LUNDE and DANIEL S. RATNER, Esqs.** represented the Respondent. **DIANNE ABELOFF, Esq.** represented the Petitioner.

COMMITTEE DETERMINATION ON CHARGES

The Petitioner filed charges with BPMC alleging that the Respondent violated N.Y. Educ. Law §§ 6530 (3-6) (McKinney's Supp. 1997) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross negligence, and,
- practicing medicine with gross incompetence.

The charges arose from the care that the Respondent provided to nine persons, Patients A through I, at University Hospital at Stony Brook, New York, from 1992 to 1995. The Petitioner withdrew an additional charge during the hearing. The record refers to the Patients by initials to protect their privacy.

Three BPMC Members, **DANIEL W. MORRISEY, O.P., Chair, DANIEL A. SHERBER, M.D. and JOSEPH B. CLEARY, M.D.** comprised the Committee who conducted the hearing in this matter, pursuant to N.Y. Pub. Health Law § 230(7)(McKinney's Supp. 1997), and who rendered the Determination which the Board now reviews. Administrative Law Judge **ELLEN SIMON** served as the Board's Administrative Officer and drafted the Determination. The Committee sustained the charges that the Respondent practice with negligence on more than one occasion in treating Patients A, C, D and E and the charge that the Respondent practiced with incompetence on more than one occasion in treating Patient B. The Committee sustained no charges relating to Patients G through I and dismissed charges that the Respondent practiced with gross negligence or gross incompetence. As to the negligence findings, the Committee found that the Respondent :

- failed to confirm that he completely excised a very aggressive carcinoma from Patient A's left breast (Allegation A1);
- failed to ascertain that the carcinoma the pathologist reported for Patient A was without free margins (Allegation A2);
- failed to document that he discussed various surgical options, including mastectomy

- with Patient A prior to her initial surgery (Allegation A5);
- failed to perform or arrange a post-operative mammogram on Patient C as soon as healing from surgery permitted (Allegation C3);
- failed to prepare an operative report to describe completely an operation on Patient D (Allegation D3); and
- performed major surgery on Patient E, a lumpectomy and axillary dissection under general anesthesia, without the necessary preoperative laboratory and radiological work-up (Allegation E1).

As to the incompetence charges, the Committee determined that the Respondent:

- diagnosed Patient B as suffering from mastitis incorrectly and treated the Patient for mastitis, rather than inflammatory carcinoma, from March 1994 to July 1994 (Allegation B); and,
- failed to follow an April 1, 1994 fine needle aspiration biopsy on Patient B with an open biopsy (Allegation B1).

The Committee concluded that, in the cases at issue in this matter, the Respondent failed to meet fundamentally accepted protocol standards and practiced his profession in a careless pattern. The Committee determined that the Respondent's misconduct warranted a substantial penalty. The Committee voted to suspend the Respondent for one year, stayed the suspension and placed the Respondent on probation for one year. The Probation Terms included requirements that the Respondent obtain a practice monitor to visit the Respondent's practice and review his records (paragraphs f and i) and that the Respondent dictate and sign all his own operative notes (paragraph g).

REVIEW HISTORY AND ISSUES

The Committee rendered their Determination on July 25, 1997. The Petitioner then commenced this proceeding on August 8, 1997 when the Board received the Notice requesting Review pursuant to N.Y. Pub. Health Law § 230-c(4)(a)(McKinney's Supp. 1997). The record fo

review contained the Committee's Determination, the hearing record, the Respondent's brief and reply brief and the Petitioner's brief and reply brief. The Board received the Respondent's brief on September 11, 1997, the Petitioner's brief on September 5, 1997, the Respondent's reply on September 11, 1997 and the Petitioner's reply on September 15, 1997. The Respondent's brief attached copies of the Respondent's Proposed Findings of Fact and Recommendations to the Committee.

Petitioner's Issues: The Petitioner asks the Board to extend the period for the stayed suspension and the probation against the Respondent's License to three years, because the one year period the Committee imposed provides an inadequate time period for the Respondent to change and overhaul his practice procedures and for the Office of Professional Medical Conduct to assure that the Respondent has actually changed his practice.

In reply, the Respondent argues that no ground exists for increasing the Penalty, because the Respondent at all times provided treatment within acceptable care standards and because the Committee's findings relate to perceived documentation deficiencies rather than careless medical treatment. The Respondent also argues that no reason exists to impose a stayed suspension, a sanction that will follow the Respondent forever in his professional career and in the National Data Bank.

Respondent's Issues: The Respondent asks the Board to dismiss the remaining charges against the Respondent, arguing that the Committee ignored overwhelming expert and factual evidence that the Respondent practiced within prevailing community standards. The Respondent argues that the complaints against the Respondent came from physicians who became angry at the Respondent due to his good faith decisions as the Acting Dean of the School of Medicine at Stony Brook. The Respondent takes full responsibility for any deficiencies in his documentation and assures the Board that he has changed his record keeping practices. The Respondent argues that the Board must dismiss the incompetence charges, because under Minielly v. Comm. of Health, 222 AD2d 750, 634 NYS 2d 856 (Third Dept. 1993), incompetence charges focus solely on credentials and there was never any question concerning the Respondent's credentials. The Respondent's brief characterizes each specific finding by the Committee as inconsistent with the evidence.

In reply, the Petitioner argues that the Committee found properly that the Respondent demonstrated he lacked the necessary skill and knowledge to treat Patient B's inflammatory

carcinoma, due to his misdiagnosis and late biopsy on the Patient. The Petitioner contends that such conduct amounts to incompetence. The Petitioner also contends that the Respondent's allegations concerning the physicians who brought complaints against the Respondent, constitute information from outside the hearing record.

REVIEW BOARD AUTHORITY

In reviewing a Committee's Determination, the Board determines: 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 the law permits [N.Y. Pub. Health Law § 230(10)(i), § 230-c(4)(b)(McKinney's Supp. 1997)]. The Board may remand a case to the Committee for further consideration [N.Y. Pub. Health Law § 230-c(4)(b)(McKinney's Supp. 1997)]. The Board's Determinations result from a majority concurrence among the Board's Members [N.Y. Pub. Health Law § 230-c(4)(c)(McKinney's Supp. 1997)].

The Review Board may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 AD 2d 86, 606 NYS 2d 381 (Third Dept. 1993) in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994), and in determining credibility Matter of Minielly v. Comm. of Health 222 AD 2d 750, 634 NYS 2d 856 (Third Dept. 1995).

REVIEW BOARD DETERMINATION

The Board has considered the record and the parties' briefs. We conducted deliberations in this case on September 26, 1997. We sustain the Committee's Determination that the Respondent practiced medicine with negligence on more than one occasion, although we modify the Determination. We dismiss the charge that the Respondent committed incompetence in treating Patient B, but we find that the Respondent's care for Patient B constituted additional negligent conduct. The Board sustains the Committee's Determination to suspend the Respondent's License for

one year, stay the suspension and place the Respondent on probation. We modify the Probation Terms to remove certain requirements, such as the practice monitor.

Charges: The Board concludes that preponderant evidence in the record supports the Committee's Determination to sustain eight allegations against the Respondent (A1, A2, A5, B, B1, C3, D3, E1). Contradictory evidence in the record merely created a factual question for the Committee to resolve in their role as fact finder. The evidence that the Committee found credible supports the Committee's Determination. By a 4-1 vote, the Board sustains the Committee's Determination that the Respondent practiced with negligence on more than one occasion, when he:

- failed to confirm that he completely excised a very aggressive carcinoma from Patient A's left breast (Allegation A1);
- failed to ascertain that the carcinoma the pathologist reported for Patient A was without free margins (Allegation A2);
- failed to perform or arrange a post-operative mammogram on Patient C as soon as healing from surgery permitted (Allegation C3); and,
- performed major surgery on Patient E, a lumpectomy and axillary dissection under general anesthesia, without the necessary preoperative laboratory and radiological work-up (Allegation E1).

We disagree with the Committee as to whether the remaining sustained allegations constitute misconduct or constitute misconduct under the same specifications that the Committee sustained.

We vote 5-0 to overturn the Committee's Determination that the Respondent practiced medicine with negligence when he:

- failed to document that he discussed various surgical options, including mastectomy with Patient A prior to her initial surgery (Allegation A5); or,
- failed to prepare an operative report to describe completely an operation on Patient I (Allegation D3).

These allegations involve documentation errors rather than a failure to provide acceptable care. No misconduct specifications charged failure to maintain accurate records. Although inadequate record keeping can amount to negligence, if the record deficiencies could affect patient care, neither

documentation errors in this instance would affect patient care.

We vote 4-1 to modify the Committee's Determination that the Respondent practiced medicine with incompetence when he:

- diagnosed Patient B as suffering from mastitis incorrectly and treated the Patient for mastitis, rather than inflammatory carcinoma, from March 1994 to July 1994 (Allegation B); and,
- failed to follow an April 1, 1994 fine needle aspiration biopsy on Patient B with an open biopsy (Allegation B1).

The Board concludes that such conduct demonstrated further carelessness or failure to practice according to accepted standards. Such conduct, therefore, amounts to negligence. In their Penalty discussion, at page 39 in their Determination, the Committee characterized the eight sustained allegations as demonstrating a failure to meet fundamental, acceptable protocol standards and a careless practice pattern. At no point does the Committee discuss why they felt that the Respondent's care for Patient B showed a lack of skill or knowledge that would amount to incompetence. The Board overturns the Committee's Determination finding that the Respondent practiced medicine incompetently in treating Patient B. We modify the Committee's Determination to find that the care for Patient B at issue in Allegations B and B1 constituted further negligent acts.

Penalty: The Board concludes that the Respondent practiced with negligence on more than one occasion, on six separate instances, in providing care to Patients A, B, C and E. The Board votes 3-2 to sustain the Committee's Determination to suspend the Respondent's License for one year and to stay the suspension. The majority agrees with the Hearing Committee that the Respondent warrants a severe Penalty for his carelessness in the cases at issue in this case and the majority agrees that revocation or actual suspension would constitute too severe a sanction. One dissenting Board Member votes against any suspension, even with the stay. The other dissenting Board Member would suspend the Respondent's license for three months, with no stay and no probation.

The Board votes 4-1 to place the Respondent on probation for one year. We conclude that probation will provide the appropriate means to assure that the Respondent has corrected the careless practice pattern that he demonstrated in the cases at issue here. We vote 5-0 to reject the Petitioner's

request that we impose a longer probation period and we vote 5-0 to reject the Respondent's request that we impose no penalty, due to the Respondent's voluntary improvement in his practice pattern. The majority concludes that one year's formal probation will assure that the Respondent has improved his practices. The majority votes further to modify the Probation Terms to remove the requirement for a practice monitor that appears at paragraphs f and i in the Probation Terms. Although the Board agrees with the Committee that the probation should provide for review on the Respondent's records we see no need for the review by a monitoring physician. We modify the Probation Terms to provide that staff from the Office for Professional Medical Conduct shall review the Respondent's records periodically during the probation for timeliness, content and documentation. We vote to modify the terms further by amending paragraph g, to remove the last sentence, requiring that the Respondent dictate and sign all his own operative reports.

ORDER

NOW, based upon this Determination, the Review Board renders the following **ORDER**:

1. The Board **SUSTAINS** the Committee's Determination that the Respondent practiced medicine with negligence on more than one occasion in treating Patients A, C and E.
2. The Board **MODIFIES** the Committee's Determination to provide that the Respondent practiced medicine with negligence in treating Patient B.
3. The Board **OVERTURNS** the Committee's Determination that the Respondent practiced medicine incompetently in treating Patient B and negligently in treating Patient D.
4. The Board **SUSTAINS** the Committee's Determination suspending the Respondent's License for one year, staying the suspension and placing the Respondent on probation for one year.
5. The Board **MODIFIES** the Committee's Determination to delete the Probation terms requiring a practice monitor and requiring that the Respondent dictate and sign all his own operative reports.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

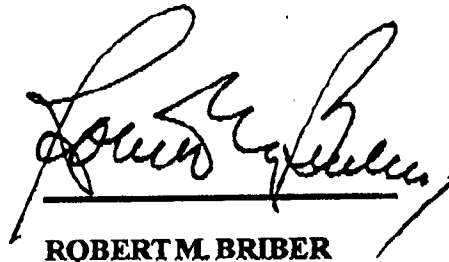
WILLIAM A. STEWART, M.D.

IN THE MATTER OF NAJI ABUMRAD, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, affirms that the attached Determination and Order reflects the Board majority's decision in the Matter of Dr. Abumrad.

DATED: Schenectady, New York

December 11, 1997



ROBERT M. BRIBER

IN THE MATTER OF NAJI ABUMRAD, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, affirms that the attached Determination and Order reflects the Board majority's decision in the Matter of Dr. Abumrad.

DATED: Delmar, New York
December 11, 1997



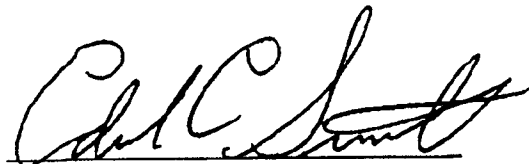
SUMNER SHAPIRO

IN THE MATTER OF NAJI ABURMRAD, M.D.

Edward C. Sinnott, M.D., a member of the Administrative Review Board for Professional Medical Conduct, affirms that the Attached Determination and Order reflects the Board majority decision in the Matter of Dr. Faiwieszewski.

DATED: Roslyn, NY.

June 13, 1997

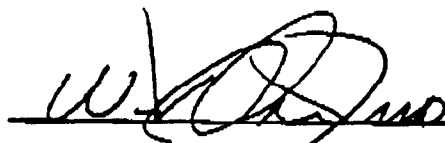

Edward C. Sinnott, M.D.

IN THE MATTER OF NAJI ABUMRAD, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, affirms that the attached Determination and Order reflects the Board majority's decision in the Matter of Dr. Abumrad.

DATED: Brooklyn, New York

12/14/, 1997



WINSTON S. PRICE, M.D.