STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

November 5, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael H. Kamalian, M.D.
1995 Route 17M
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NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2512
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Albany, New York 12237

RE: In the Matter of Michael H. Kamalian, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-123) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

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

In the Matter of

Michael H. Kamalian, 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. 07-123

Before ARB Members Grossman, Lynch, Pellman, Wagle and Wilson
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Lee A. Davis, Esq.
For the Respondent: Robert R. Sappe, Esq.

Following a hearing below, a BPMC Committee found that the Respondent committed professional misconduct in performing surgery on seven patients. The Committee voted to censure and reprimand the Respondent, to limit the Respondent's License to practice medicine in New York State (License) and to place the Respondent on probation for 18 months under the terms that appear as the Appendix to the Committee's Determination. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney Supp. 2007), the Respondent asks the ARB to overturn the Committee's findings on the charges and both parties request that the ARB modify the penalty that the Committee imposed. After reviewing the hearing record and the parties' review submissions, the ARB votes unanimously to overturn the Committee and remove the censure and reprimand. The ARB suspends the Respondent's License for two years and stays the final year of the suspension. The ARB affirms the Committee's Determination to limit the Respondent's License and to place the Respondent on probation, but the ARB modifies the terms for the limitation and we extend the probation period from 18 months to 3 years.

Committee Determination on the Charges

The Committee conducted a hearing on charges that the Respondent, an orthopedic surgeon, violated New York Education Law (EL) §§ 6530(2-6), 6530(21) & 6530(32) (McKinney Supp. 2007) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- 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,
- willfully making or filing a false report, and,
- failing to maintain accurate records.

The charges related to surgery that the Respondent performed on seven persons (Patients A-G). The record identifies the Patients by initials to protect patient privacy. Following the hearing, the Committee rendered the Determination now under review.

The Committee dismissed all charges relating to Patients E and G and all charges alleging fraud and willfully filing false reports. The Committee sustained charges that the Respondent practiced with negligence on more than one occasion in treating Patients A, B, C, D and F, that the Respondent practiced with gross negligence in treating Patient B, that the Respondent practiced with incompetence on more than one occasion in treating Patients B and C and that the Respondent failed to maintain accurate records for Patients A, C, D and F.

The Committee determined that the Respondent practiced below accepted care standards by making an incision on the wrong hip for Patient A during a procedure to repair a fractured left hip. The Committee determined that the Respondent failed to make reasonable efforts to inform the Patient's family concerning the error. The Committee determined that the Respondent practiced with negligence, incompetence and gross negligence in treating Patient B following surgery to repair fractures from a dirt bike accident. The Committee found that the Respondent

should have hospitalized the Patient for observation of a possible compartment syndrome. The Committee found that, instead, the Respondent sent the Patient home the same day as the surgery, with instructions to keep the leg elevated. The Committee found that compartment syndrome could develop within hours of surgery, that the discharge made it difficult to monitor the Patient and that the Patient had a history of non-compliance with treatment. The Committee also found that the Respondent failed to act expeditiously to intervene surgically on the day following the surgery on Patient B, when the Patient presented with symptoms of a problem. The Committee determined that the Respondent practiced with negligence and incompetence and that the Respondent failed to maintain accurate records for Patient C for surgery to treat pseudoarthrosis, a rare, congenital condition. The Committee found that the Respondent should have referred the 9-year-old Patient to a pediatric orthopedic surgeon, as the best chance to correct the condition on the first surgery. The Committee also found that the Respondent failed to harvest bone grafting material from the Patient's iliac crest, failed to keep the Patient hospitalized following the surgery and failed to record accurately the site from where the Respondent harvested bone-grafting material. The Committee found that the Respondent practiced with negligence and that the Respondent failed to maintain an accurate record in performing two surgeries on Patient D for a dislocated and broken wrist. The Committee found that the Respondent's initial surgery on the Patient corrected an emergent nerve condition due to the dislocation. The Committee found further that the second surgery should result in the correct alignment of the wrist bones. The Committee concluded that the second surgery on Patient D failed to correct the alignment. The Committee concluded further that the Respondent failed to note accurately the condition of the wrist after the surgeries. The Committee determined that the Respondent practiced with negligence and failed to maintain an accurate record for Patient F in performing surgery on the Patient for advanced osteoarthritis of the left hip. The Committee found that the Respondent obtained consent from the Patient to perform a total hip replacement and billed the Patient for a total hip replacement. The Committee found further that the Respondent performed a different procedure, a bipolar replacement, and that the Respondent

failed to justify or provide any basis in the record for changing the procedure to which the Patient consented.

In reaching their findings of fact, the Committee credited the testimony by the Petitioner's expert witness, Louis J. Benton, Jr., M.D., a board certified orthopedic surgeon. The Committee found no bias on Dr. Benton's part and the Committee found Dr. Benton forthright in his testimony. The Committee found Dr. Benton more credible than the Respondent's expert witness, Karl Barbera, M.D., another board certified orthopedic surgeon. The Committee found Dr. Barbera to be an advocate rather than an objective reviewer. The Committee found testimony by the Respondent evasive and obfuscating and the Committee found the Respondent less than forthcoming. The Committee noted that the Respondent blamed others for shortcomings in the care at issue.

The Committee voted to censure and reprimand the Respondent and to place the Respondent on probation for eighteen months, under the terms that appear as Appendix II. The probation terms at Paragraph 8 require that the Respondent enroll in and complete a continuing education program in: total hip joint surgery, medical record keeping and interpreting radiological records. The probation terms at Paragraph 9 require that the Respondent practice with a monitor. The Committee's Determination also prohibited the Respondent from performing any pediatric orthopedic reconstructive surgery and hand and wrist orthopedic surgery and ordered the Respondent to refer such cases to an appropriate orthopedic surgical specialist. The Committee stated that the Respondent exhibited no remorse for the errors he committed and blamed others for substandard care. The Committee also found the Respondent's medical knowledge deficient and found the deficiency resulted in inappropriate or less than adequate medical care.

Review History and Issues

The Committee rendered their Determination on June 13, 2007. This proceeding commenced on June 26, 2007, when the ARB received the Petitioner's Notice requesting a

Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and reply brief and the Respondent's brief and response brief. The record closed when the ARB received both parties' response briefs on August 2, 2007.

The Respondent challenged all charges that the Committee sustained and referred the ARB to the Respondent's brief from the hearing. The Respondent's review brief challenged specifically the Committee's Determination that the Respondent practiced with gross negligence and with incompetence in treating Patient B. The Respondent contends further that the Committee imposed an overly harsh penalty.

The Petitioner made no challenge to the Committee's findings of fact or conclusions. The Petitioner argued that the Committee's findings warrant a more severe penalty than the Committee imposed. The Petitioner requests that the ARB revoke the Respondent's License, or in the alternative, that the ARB impose a period of actual suspension, increase the term on probation to three year and to retain a practice monitor as a probation term.

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 substitute our judgment and 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 in full the Committee's findings on the charges. The ARB overturns the Committee's Determination to censure and reprimand the Respondent. The ARB votes to suspend the Respondent's License for two years and to stay one year of the suspension. The ARB affirms the Committee's

Determination to limit the Respondent's License, but we modify the limitation. The ARB affirms the Committee's Determination to place the Respondent on probation, but we extend the probation term from eighteen months to three years. The probation shall commence after the one-year actual suspension.

The Respondent's challenge to the Committee's findings in general amounts to a challenge to the Committee's determination in crediting the testimony by the Petitioner's expert, Dr. Benton, over the conflicting testimony by the Respondent's expert witness, Dr. Barbera, and the Respondent himself. The ARB defers to the Committee, as the fact finder, as to the Committee's judgment on the credibility of the witnesses whom the Committee observed. The testimony by Dr. Benton and the medical records in evidence provided sufficient credible evidence for the Committee to determine that the Respondent failed to maintain accurate records, that the Respondent practiced with negligence on more than one occasion in treating five Patients, that the Respondent practiced with incompetence on more than one occasion in treating Patients B and C and that the Respondent practiced with gross negligence in treating Patient B.

The Respondent made a specific challenge to the Committee's determination on incompetence in treating Patient B, on the grounds that the Committee based that determination on erroneous findings that the Patient suffered his injury in a "high energy accident", that the Patient would be home alone following the surgery and that the Patient was non-compliant. The ARB rejects those arguments by the Respondent. We agree with the Petitioner that the Committee based their conclusions on incompetence on the Committee's Findings of Fact 5-9, at pages 5 in the Committee's Determination and that those Findings make no mention of non-compliance or the Patient being home alone. We also agree with the Petitioner that the record, including notes and testimony by the Respondent, also demonstrates that Patient B suffered

injuries in a "high energy accident" and that Patient B would be home alone following the release after surgery. The ARB also finds grounds in the record for the Committee's Determination that the Patient had been non-compliant. The record demonstrated that, three years prior to treating Patient A for the broken leg, the Respondent treated the Patient for a broken arm and the Patient removed part or all of the cast on his arm on four occasions. The Petitioner's expert testified that this history was significant in showing a tendency to lack comprehension about complying with instructions to keep the broken leg elevated.

The Respondent's review brief also challenged the Committee's finding that the Respondent committed gross negligence in treating Patient B. The Respondent argued that the Patient's post-operative symptoms were vague and so no basis existed for the Committee to conclude that the Respondent failed to intervene surgically at the first sign of compartment syndrome. The ARB rejects that argument as well. Evidence from the hospital record for the Patient's care indicated that the Patient presented at the Respondent's office on the day following surgery with signs of sensory deprivation and restricted movement of toes. The Committee found from that evidence that the Patient showed indications of compartment syndrome and that the Respondent should have intervened surgically at that point.

The Respondent argued that the Committee imposed an overly harsh penalty. The Respondent based the argument on penalty, in part, on the prior arguments that the record failed to support the findings on gross negligence and incompetence in treating Patient B. The ARB has rejected those arguments already. The Respondent also argued that the Committee penalized the Respondent for defending himself because the Committee found that the Respondent lacked remorse and that the Respondent blamed others for his mistakes. The ARB rejects that argument and we again defer to the Committee in their assessment of the Respondent's testimony. The

ARB also agrees that the Respondent's testimony showed a lack of remorse and a failure to take responsibility. For example, the Respondent performed wrong side surgery on Patient A. The operating surgeon bears responsibility for knowing precisely the surgery to perform. The Respondent also bore responsibility to inform the Patient's family concerning the error. The Respondent failed to inform the family. In both instances, the Respondent tried to blame others for the Respondent's errors.

In reviewing the penalty the Committee imposed, the ARB finds the penalty inappropriate and inconsistent with the Committee's findings and conclusions. The Committee found multiple acts of serious misconduct involving the treatment for several patients. The Committee found the failure to follow accepted medical standards, or practicing with negligence on more than one occasion, in treating five Patients, and the Committee found that failure rose to egregious levels, or practicing with gross negligence, in one of the five patients. The Committee also found that the Respondent exhibited a lack of skill or knowledge necessary to practice medicine safely and effectively, or practicing with incompetence on more than one occasion, in treating two Patients. The Committee also found a lack of remorse and responsibility on the Respondent's part. The ARB agrees with the Committee that the sanction for such misconduct should include continuing education requirements, practice monitoring and a limitation on the Respondent's practice, but we find the need to modify the method in which the Committee imposed each of those sanctions. The ARB finds a censure and reprimand totally inadequate as a sanction. We conclude that the Respondent must spend actual time on suspension.

Although retraining or continuing education can address a deficit in knowledge and/or skill in practice, education or retraining provides no remedy to redress the failure to comply with accepted practice standards and the risk that such failure poses to patients. The ARB concludes

that the Respondent requires a "wake up" call to allow the Respondent to reflect on the need to correct his practice pattern and to show him that the continued failure to follow practice standards can result in his permanent removal from medical practice. The ARB suspends the Respondent from practice for two years and we stay the final year of the suspension.

Following the suspension, the ARB places the Respondent on probation under the terms that appear at Appendix II to the Committee's Determination. Those terms include continuing education and practice monitoring. The continuing education under the probation will address the Respondent's practice with incompetence on more than one occasion in treating Patients B and C. Practicing under a monitoring physician will aid in assessing whether the Respondent has improved his skills and knowledge and adjusted his practice to comply with accepted standards. The Respondent may choose to begin the continuing education during the actual suspension period. The ARB concludes, however, that eighteen provides an insufficient time to monitor the Respondent's practice. The ARB imposes the probation for three years.

The ARB agrees with the Committee that the Respondent's care for Patient C demonstrates that the Respondent should not perform reconstructive surgery on children, but we modify the wording on the limitation to make the limitation more clear. The ARB limits the Respondent's License to prohibit the Respondent from performing orthopedic reconstructive surgery on any person under sixteen years of age. The Respondent shall refer all such persons to an appropriate pediatric orthopedic surgeon.

The ARB concludes that the penalty we have imposed will address the misconduct that the Respondent committed and we reject the request by the Petitioner that we revoke the Respondent's License.

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 practiced with negligence on more than one occasion, gross negligence and incompetence on more than occasion and that the Respondent failed to maintain accurate records.
2. The ARB overturns the Committee's Determination to censure and reprimand the Respondent.
3. The ARB votes 5-0 to suspend the Respondent's License for two years and to stay the final year of the suspension.
4. The ARB affirms the Committee's Determination to limit the Respondent's License, but we modify the terms of the limitation, as we indicated above.
5. The ARB affirms the Committee's Determination to place the Respondent on probation, but we modify the Committee's Determination by increasing the period on probation from eighteen months to three years.

Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Linda Prescott Wilson
Therese G. Lynch, M.D.

In the Matter of Michael H. Kamalian, M.D.

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

Dated: 2 Nov 07 /2007

Linda Prescott Wilson

In the Matter of Michael H. Kamalian, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Kamalian.

Dated: Oct. 26, 2007

Thea Graves Pellman

In the Matter of Michael H. Kamalian, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Kamalian.

Dated: 10/27, 2007

Datta G. Wagle, M.D.

In the Matter of Michael H. Kamalian, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Kamalian.

Dated: October 26 2007

S L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Michael H. Kamalian, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Kamalian.

Dated: October 25, 2007

Therese G. Lynch M.D.

Therese G. Lynch, M.D.

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,

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure