STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

June 13, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael H. Kamalian, M.D.
1995 Route 17M
Goshen, New York 10924

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Lee A. Davis, Esq.
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Corning Tower – ESP – Room 2512
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 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), and '230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the 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:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER

OF

MICHAEL H. KAMALIAN M.D.,

Respondent

DETERMINATION

AND

ORDER

BPMC #07-123

A Notice of Hearing dated October 18, 2006, and a Statement of Charges, dated November 3, 2006, were served upon the Respondent, Michael H. Kamalian, M.D. **ALEXANDER M. YVARS, M.D. (Chair), WALTER T. GILSDORF, M.D. and THOMAS W. KING, JR., M.P.A.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Esq., Assistant Counsel, Bureau of Professional Medical Conduct. The Respondent appeared by Feldman, Kleidman & Coffey, Robert R. Sappe, Esq. of Counsel. Evidence was received, witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Dates of Hearing:

November 14, 2006
December 5, 2006
December 14, 2006
December 19, 2006
January 29, 2007
January 30, 2007
March 6, 2007

Date of Deliberations:

April 23, 2007

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated six categories of professional misconduct, specifically gross negligence; negligence on more than one occasion; incompetence on more than one occasion; fraudulent practice of medicine; willfully making or filing a false report and failing to maintain records which accurately reflect the care provided to a patient. A copy of the Amended Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers and/or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Michael H. Kamalian, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about September 1, 1970, by the issuance of license number 107040 by the New York State Education Department. (Ex. 4)

PATIENT A

2. Respondent provided medical care to Patient A, a 91year old female, at the Horton Medical Center (hereinafter HMC) from about May 29, 1999 to June 11, 1999. Patient A presented at the HMC on May 29, 1999, with a fractured left hip as a result of a fall and Alzheimer's disease. She was scheduled for surgery on her left hip. (T.115-116; Ex. 5)

3. On or about June 1, 1999, the Respondent performed surgery on Patient A at the HMC to repair her fractured left hip. Upon initiating the surgery, the Respondent mistakenly made an incision into the patient's right hip area. The operating surgeon is responsible for knowing precisely what surgical procedure the patient is to have and performing that surgery. The Respondent did not initially know this, nor did he initially perform the correct surgical procedure on Patient A. (T.119-124; Ex. 5)

4. When a surgical error occurs relating to a patient with diminished mental capacity, the operating surgeon has a duty to make all reasonable efforts to inform the responsible party of the error. The Respondent did not do that with respect to Patient A. (T.125-131, Ex. 5)

PATIENT B

5. On or about November 7, 1996, through on about July 1, 1997. Respondent provided medical care to Patient B, a 21 year old male, at the Arden Hill Hospital (hereafter AHH). On or about November 7, 1996, Patient B presented at the AHH with a displaced comminuted fracture of the right tibia and fibula as a result of a dirt bike accident. (Ex. 6).

6. On or about November 7, 1996, the Respondent performed an open reduction internal fixation surgery to repair Patient B's right tibia and fibula fracture. (Ex. 6)

7. An injury such as Patient B had, which was a result of his dirt bike accident, is considered a high energy accident. In cases involving a high energy injury a physician has to be concerned with both the injury to the bones and the injury to the soft tissue. The soft tissue includes, but is not limited to muscles, ligaments, nerves and vascular structures. (T.310-313, 389)

8. To an enable a physician to assess soft tissue injury and any possible complications for a patient who presents such as Patient B did, and since compartment syndrome can develop in a matter or hours, the patient should be hospitalized so that the patient can be professionally monitored.

The Respondent did not do this. (T.318-319,

322-327, 331-333, 379-381, 1257-1258; Exs. 6 &22)

9. When a patient presents at a physician's office as Patient B did on November 8, 1996 with signs of sensory deprivation and restricted movement of toes, which are indications of compartment syndrome, the physician should intervene surgically. The Respondent did not do this. (T.336-339, 349-350, 386-387; Exs. 6 & 22)

PATIENT C

10. From on or about October 2, 1995 through on or about September 3, 1996, the Respondent provided medical care to a 9 year old male patient, Patient C, at the AHH and in his office in Goshen, New York. Patient C presented with a diagnosis of congenital pseudoarthrosis of the left tibia. On or about December 4, 1995, the Respondent operated on Patient C to correct the congenital pseudoarthrosis of Patient C's left tibia. (T.396; Exs. 7 & 8)

11. When a patient such as Patient C presents to a general orthopedist, the physician rather than perform surgery on the patient, should refer such a patient to a pediatric orthopedist for treatment of the pseudoarthrosis. The Respondent did not do this. (T.398-401, 417-418, 442; Ex. 7 & 8)

12. When performing surgery of the type that was performed on Patient C, the iliac crest is the most preferred site to harvest bone from for grafting. A physician should note in the record the site from where he harvested the bone that was used for bone grafting. The Respondent did not do this. (T. 405-4-7, 417-418, 443-445; Exs. 7 & 8)

13. When a patient such as Patient C undergoes the type of surgery that was performed on December 4, 1995, the patient should not be discharged from the hospital on the same day of surgery. The Respondent discharged Patient C from AHH on the same day he performed surgery on him to correct his congenital pseudoarthrosis. (T.410-412, 418; Exs. 7 & 8)

PATIENT D

14. From on or about November 9, 1996 through December 24, 1996, the Respondent treated Patient D, a 31 year old male, at AHH. Patient D presented with peri-lunate dislocation and a fracture of the right ulnar styloid.

15. When a patient presents as Patient D, the admission note should indicate the status of the median nerve. The Respondent's history and

physical for this patient did adequately note the involvement of that nerve. (T.481-482; Ex. 9)

16. When a patient presents as Patient D, a physician's medical record should specifically note the condition of this patient's wrist prior to surgery, including what bones are fractured and/or dislocated and any nerve involvement, and should accurately note the condition of the wrist after surgery. The Respondent did not do this for the surgery performed on this patient on November 9, 1996. (T.483-491; Exs. 9 & 12)

17. When Patient D presented at AHH in November 9, 1996, his emergent condition was the dislocation of his wrist, which was interfering with the normal functioning of his median nerve. The surgery performed on Patient D by the Respondent on November 9, 1996, corrected that emergent median nerve condition. (T.523-527; Ex. 9)

18. When a patient presents to a physician as Patient D on November 12, 1996 did, following a closed reduction surgery to relieve median nerve pressure, the follow-up surgery should result in a correct alignment of the wrist bones. The surgery that the Respondent performed on Patient D on November 12, 1996, did not do that. (T.501-505, 515; Exs. 10 & 12)

19. On or about November 12, 1996, the Respondent attempted to perform an open reduction of Patient D's right wrist using a dorsal incision.

A physician performing this type of surgery can appropriately use either a volar or dorsal incision. (T.543)

20. When a patient presents as Patient D did prior to the November 12, 1996 surgery, a physician's medical record should note the condition of the wrist prior to surgery, specifically which bones are involved and whether or not compression on the median nerve has been resolved and should accurately note the condition of the wrist after surgery. The Respondent's record for the November 17, 1996 surgery performed on Patient D did not do this. (T. 493-496, 503, 516; Exs. 10 & 12)

PATIENT E

21. From on or about January 14, 2002 through January 15, 2002, the Respondent provided care and treatment to Patient E, an 81 year old female at AHH. Patient E presented advanced osteoarthritis of the left hip and was scheduled for total hip replacement surgery. (T.166; Exs. 13 & E)

22. On or about January 14, 2004, the Respondent performed a total hip replacement surgery on Patient E. When performing such surgery, upon fixing the components, a surgeon should move the replacement hip through various motions and alignments in order to make a judgment call as to whether or not the prostheses is sufficiently stable. The Respondent did that with respect to Patient E and found the hip sufficiently stable. (T.1533; Ex.

13)

PATIENT F

23. From on or about May 3, 1999 through May 16, 1999, the Respondent provided medical care to Patient F, a 69 year old male, at AHH. Patient F presented with advanced osteoarthritis of the right hip and was scheduled for total hip replacement surgery. (T.221-222; Exs. 15 & 16)

24. On or about May 3, 1999, the Respondent performed a bipolar hip replacement on Patient F. When a surgeon schedules a patient for a total hip replacement, which is the better treatment for advanced osteoarthritis, and converts to a bipolar hip replacement, the surgeon should have a basis for this; should state that justification in the medical record and the patient consent should specifically note the possibility of this surgical conversion. The Respondent did not do this for the surgery he performed on Patient F on May 3, 1999. (T.224-227, 232-233, 240, 247-248, 251; Ex. 15)

25. A discharge summary should accurately reflect the procedure performed on the patient. The Respondent's discharge summary for the surgery of Patient F on May 3, 1999, accurately stated that the Respondent replaced an acetabular component of Patient F's right hip. (T.250-251; Ex. 15)

26. A physician who converts a planned total hip replacement surgery to a

bipolar hip replacement surgery should inform the patient why he converted to the bipolar replacement surgery. The Respondent did this for the surgery performed on Patient F on May 3, 1999. (T.1584; Ex. 15)

27. When a surgeon performs bipolar hip replacement surgery, rather than total hip replacement surgery, he should bill for bipolar hip replacement surgery. The Respondent performed bipolar hip replacement surgery on Patient F but billed for total hip replacement surgery. (T.244-247, 252; Ex. 16)

PATIENT G

28. Respondent provided medical care to Patient G, a 38 year old female, from on or about May 28, 1997 through September 2, 1997 in his office in Goshen, New York. Patient G presented with pain and swelling of the left knee as a result of a fall and opted to have arthroscopic surgery to repair her knee joint. On or about July 28, 1997, the Respondent performed a partial lateral meniscectomy on Patient G's left knee (T. 575, Ex. 19).

29. On or about August 20, 1997 the Respondent saw Patient G on a surgical follow-up visit. The patient still had swelling of the knee joint and was referred to AHH for a doppler test and aspiration and culture of the wound. The culture indicated a small amount of staph aureus. The Respondent prescribed Cipro for this patient to treat the staph aureus. When

a Patient presents as Patient G did on August 20, 1997 with subsequent laboratory tests results showing a small amount of staph aureus, it is within the appropriate physician's judgment to treat the patient's symptoms solely with a course of oral antibiotics like Cipro. (T. 577-578, 1670, 1636; Exs. 19 & 20).

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charge, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation. It should be noted that Factual Allegations D.1 and D.2 were withdrawn by the Petitioner.

Paragraph A.1:	**(2,3)**
Paragraph A.2:	**(4)**
Paragraph B.1:	**(5-8)**
Paragraph B.2:	**(9)**
Paragraph C.1:	**(10,11)**
Paragraph C.2:	**(12)**
Paragraph C.3:	**(12)**
Paragraph C.4:	**(13)**
Paragraph D.4:	**(16)**
Paragraph D.6:	**(18)**
Paragraph D.8:	**(20)**
Paragraph F.1:	**(23,24)**
Paragraph F.3:	**(24)**
Paragraph F.5:	**(27)**

The Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification.

INCOMPETENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs B. and B.1., C. and C.l.)

GROSS NEGLIGENCE

Fourth Specification: (Paragraphs B. and B.2)

NEGLIGENCE ON MORE THAN ONE OCCASION

Tenth Specification: (Paragraphs A. and A.1., A. and A.2., B. and B.l., B. and B.2., C. and C.1., C. and C.2., C. and C.4., D. and D.4., D. and D.6., D and D.8., F. and F.1., and F. and F.3.)

FAILURE TO MAINTAIN RECORDS WHICH ACCURATELY REFLECT THE CARE PROVIDED

Sixteenth Specification: (Paragraphs C. and C.2., C. and C.3., D. and D.4.; D. and D.8, and F. and F.8.)

The Committee concluded that the Eleventh through Thirteenth Specification of Fraud, and the Fourteenth through Fifteenth Specification of False Report should **not be sustained**, either because the underlying allegation was not proven or the Respondent's conduct did not meet the definition of what was required to make a finding of fraud or willful action.

DISCUSSION

Respondent was charged with violating four subdivisions of professional misconduct within the meaning of Education Law §6530 including gross negligence, negligence on more than one occasions, gross incompetence and incompetence on more than one occasions. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum from the General Counsel for the Department of Health. This document, entitled *"Definitions of Professional Misconduct Under the New York Education Law"* sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Using the above-referenced definitions where applicable as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the specification of negligence on more than one occasion, incompetence on more than one occasions, gross negligence and failure to maintain records which accurately reflect the care provided should be sustained.

The Committee also concluded that the specifications of fraudulent practice of medicine and willfully filing a false report should not be sustained.

The rational for the Committee's conclusions is set forth below:

The Petitioner presented Louis J. Benton, Jr., M.D. as its sole expert witness. Dr. Benton is board certified in orthopedic surgery. There was no evidence of any bias on the part of Dr. Benton or his unsuitability as an expert witness. The Respondent present Karl Barbera, M.D. as his sole expert witness. Dr. Barbera is board certified in orthopedic surgery.

The Committee found the testimony of Dr. Benton more credible in most cases and was found to be forthright, unbiased and the Committee felt he gave honest medical opinions as to the care provided. Dr. Barbera was found to be an advocate rather than an objective reviewer of the medical care provided by the Respondent.

The Respondent also presented his own testimony to support his conduct. The Committee found his testimony not forthcoming, evasive and at times obfuscating. He often blamed others for the shortcomings in the care provided. For the most part, he was found to be not credible.

PATIENT A:

The Committee concurred with the Department's expert that ultimately it was the Respondent's duty to check the records prior to starting the surgery to

insure that he was performing the procedure on the correct anatomical location of the patient. He didn't do this. The Respondent, although admitting responsibility for the initial wrong-side surgery, also noted his belief that it was a group error.

Subsequently the responsible family members were not notified of the incident. The Committee found that the Respondent had an ethical duty to notify the family of the error, but he failed to take the necessary steps to insure they were informed. There was no indication in the record what efforts Respondent made to contact the patient's family, nor did the Respondent instruct the nursing staff on the floor to contact him when the patient's family visited.

His conduct with respect to this patient was found to be negligent and constituted a failure to maintain accurate patient records.

PATIENT B:

The Committee concurred with the Department's expert's opinion that this patient needed inpatient observation and was not a candidate for post surgery same day discharge, given the risk of compartment syndrome developing. Although not high in percentage of occurrence, compartment syndrome should always be considered, and if it does develop, steps should be taken to act at the earliest possible time so as to minimize the injury to the patient. Both experts were in agreement that the detrimental effects of compartment syndrome can develop within hours of onset.

Given that this patient was home alone, and that this patient had a history of non-compliance, he needed close professional monitoring that could only be provided in a hospital setting. Additionally, the Respondent failed to do an adequate evaluation of the patient's leg and the degree of pain relative to the injury which is a good indicator of whether or not compartment syndrome is developing.

On November 8, 1996, the Respondent saw the patient in his office. Based on the record on that date, symptoms of a problem were present, but the Respondent failed to take any action. Had the patient been in the hospital, a consultation may have been requested resulting in an earlier diagnosis. The Respondent did not act expeditiously to surgically intervene, given the patient's presentation on November 8, 1996.

Respondent's conduct with respect to this patient was found to be incompetent, negligent and grossly negligent.

PATIENT C:

The Committee found the care provided this patient was inappropriate. This patient needed surgery to correct a congenital pseudoarthrosis of the left tibia. There was no record that the Respondent ever contacted the patient's prior physician to discuss the care, and inquire why surgery had not been previously considered. The Committee agrees with the Department's expert that this patient should have been provided with the best possible chance for success on the first

surgery by referring the patient to a pediatric orthopedic surgeon, notwithstanding the wishes of the patient's parents. A physician has the benefit of knowledge of what is the best care for the patient and has a duty to both direct the patient to appropriate care and to decline providing less than optimum care, irregardless of the patient's insistence otherwise.

The best treatment for the patient would have been a referral to a pediatric orthopedic surgeon which the Respondent did not do.

The surgical record failed to contain any reference to where the Respondent harvested the bone material for the bone graft. Nor did it contain any reference to an incision relating to the harvesting of the bone. The ideal location for harvesting the bone is from the iliac crest. Although the Respondent testified he obtained the bone from there, he did not note as such in the medical record.

The Committee also concurred with the Respondent's expert that the patient should not have been discharged the same say of his surgery. The patient should have been admitted so that he could be professionally observed for any adverse medical development. Respondent's conduct with respect to this patient amounted to incompetence, negligence and constituted a failure to maintain accurate patient records.

PATIENT D:

The Committee concluded that the Respondent's admission note, although it did not fully describe the involvement of the median nerve, did make note of the median nerve, and this was sufficient.

However, the Respondent's operative note was deemed incomplete in its description of Patient D's wrist. There was no indication in the note of what bones were out of alignment and the conclusion in the note was that there was satisfactory alignment when that was not the case.

It could conceivably be surmised that the Respondent planned a two part surgery on November 9, 1996, and therefore the allegation that he failed to repair the injury was not sustained since he did alleviate the median nerve compression with the November 9, 1996 surgery. Assuming his plan was a two-part surgery, the follow-up surgery of November 12, 1996 should have achieved proper alignment of the wrist. The record shows that was not obtained, therefore the allegation of **Paragraph D.6.** was found to be proved.

Both the Petitioner's Expert and the Respondent's Expert opined that the choice of which incision to use, dorsal versus volar, is a matter for the surgeon's preference and there is no one incision which is correct. Therefore, the allegation that the Respondent inappropriately made a dorsal incision was not sustained.

As noted above, for the November 9, 1996 surgery, the Committee found that the Respondent's note regarding the condition of the wrist after the November

12, 1996 surgery was not accurate. The medical records indicate alignment had not been achieved, yet the Respondent's note states that it was. Nor is there any discussion of the median nerve or relief of the compression of that nerve noted in the November 12, 1996 surgical record. This is a departure from accepted standards of care.

The Committee concurred with Respondent that the Petitioner failed to prove Allegation D.9., that no tomograms were obtained between November 12, 1996 and December 24, 1996. In this instance, the Petitioner had not met it's burden of proof by simply stating no records could be found for the time period noted.

The Respondent's conduct with respect to Patient D was found to be negligent and constituted a failure to maintain accurate patient records.

PATIENT E:

The Committee concluded that the Petitioner did not present sufficient evidence to prove this allegation. Although there was some instability of the hip during surgery, in the Respondent's judgment the instability was evident only at an extreme angle of distention, and this was acceptable. The fact that the Respondent spoke to the patient's family after surgery about his concern regarding the stability of the joint does not prove that the hip was sufficiently unstable during surgery to warrant an in-surgery revision. Nor does the fact that the hip subsequently

dislocated prove that an in-surgery revision should have been performed. In this case, it was a judgment call for the Respondent to make.

PATIENT F:

The Committee concurred with the Petitioner that the switching from a total hip replacement to a bipolar was inappropriate in that the Respondent failed to justify or provide any basis in the record for changing the procedure that the patient consented to. This failure by the Respondent led the Committee to sustain **Factual Allegations F.1., and F.3.** Specifically, Respondent's note did not provide any documentation as to how he came to the conclusion that the patient's acetabular was too thin to support a total hip replacement.

Both the Petitioner's expert and the Respondent's expert found the discharge summary accurate in that an acetabular component of the patient's hip was replaced. Therefore, **Factual Allegation F.2.** was not proved.

The Committee concurred with the Respondent that although not ideal, Respondent's note regarding the informing the patient about the reason for switching to a bipolar hip replacement because of the status of the acetabular was sufficient as to be within the standard of care.

Both parties were in consensus that the Respondent incorrectly billed for a total hip replacement when he actually performed a bipolar hip replacement. Therefore this factual allegation was sustained.

The Respondent's conduct with respect to Patient F. was found to be negligent and constitued a failure to maintain accurate patient records.

PATIENT G:

The Committee concluded the care provided the patient was within the standard of care. The Committee found that the medical record evidence presented by the Petitioner was insufficient to conclude that a deviation from the standard of care occurred.

The Committee agreed with Respondent's Expert that an arthoscopic lavage was not required in every case which presents as Patient G's did. At the end of Respondent's care for this patient, there was no evidence of degradation of the condition of her knee joint to warrant performing an arthoscopic lavage.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that the Respondent should be Censured and Reprimanded and his license to practice medicine in New York State should be placed **on probation for a period of eighteen (18) months.** The terms of the probation are specifically set forth in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to

statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee found the Respondent exhibited no remorse for the errors in care that he committed. In some instanced he blamed others for the delivery of substandard care when it was his patient and his responsibility.

The Committee also concluded that in some cases his knowledge of medicine was deficient and led to the provision of inappropriate or less than adequate medical care. The terms of probation are meant to remedy these deficiencies.

ORDER

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

1, The **First, Fourth, Tenth and Sixteenth Specification** of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination an Order) are **SUSTAINED;**

2, The Respondent is hereby **Centured and Reprimanded;**

3. The Respondent is prohibited from performing any pediatric orthopedic reconstructive surgery and hand and wrist orthopedic surgery and shall refer those cases to an appropriate orthopedic surgical specialist.

4. The Respondent's license is placed on **PROBATION FOR EIGHTEEN (18) MONTHS,** the terms of the probation are contained in Appendix II attached hereto and made a part of this Determination and Order.

DATED: 6.11.07 **, New York**

_____**, 2007**

ALEXANDER M. YVARS, M.D. (Chair)

WALTER T. GILSDORF, M.D.
THOMAS W. KING, JR., M.P.A., P.E.

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APPENDIX I

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

IN THE MATTER

OF

MICHAEL H. KAMALIAN, M.D.

AMENDED STATEMENT OF CHARGES

MICHAEL H. KAMALIAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 1, 1970, by the issuance of license number 107040 by the New York State Education Department. Respondent is registered with the New York State Education Department through October 31, 2008.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a female patient 91 years old when treated for a left hip fracture from on or about May 29, 1999 through on or about June 11, 1999 at Horton Medical Center in Middletown, New York. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. On or about June 1, 1999, Respondent inappropriately made an initial incision on Patient A's right hip, rather than left hip; and
2. Respondent failed to inform Patient A's family of the wrong-sided incision until he was confronted by the family on the issue on June 6, 1999; five days after the error occurred.

B. Respondent provided medical care and treatment to Patient B, a male patient 21 years old when treated for a displaced comminuted fracture of his right tibia and fibula following a motorcycle accident, from on or about

November 7, 1996 through on or about July 1, 1997 at Arden Hill Hospital and at his office in Goshen, New York. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately discharged Patient B from the hospital on November 7, 1996, the same day of the open reduction internal fixation of the fracture site, given the potential for soft tissue injury, swelling, development of compartment syndrom, and the need to closely monitor Patient B for leg elevation and the need for potential quick surgical intervention; and

2. Respondent failed to surgically intervene at the earliest indication of a compartment syndrom.

C. Respondent provided medical care and treatment to Patient C, a male patient 9 years old when treated for congenital pseudoarthrosis of the left tibia from on or about October 2, 1995 through on or about September 3, 1996 at Arden Hill Hospital and at his office in Goshen, New York. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately performed surgery in an attempt to correct the Patient C's pseudoarthrosis rather than refer Patient C to a pediatric orthopedic surgeon;

2. Respondent inappropriately failed to harvest and/or record the harvesting of bone from Patient C's iliac crest to use for bone grafting during the surgery;

3. Respondent failed to identify in his operative note the site from which he harvested Patient C's autogenous bone; and

4. Respondent inappropriately discharged Patient C from Arden Hill Hospital on the same day of the 3 ¾ hour surgery.

D. Respondent provided medical care and treatment to Patient D, a male patient 31 years old when treated for a fracture of the right ulnar styloid and dislocation of the right carpal lunate with median nerve involvement from on or about November 9, 1996 through on or about December 24, 1996 at Arden Hill Hospital in Goshen, New York. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately performed the surgery on Patient D rather than referring Patient D to an orthopedic surgeon specializing in upper extremity trauma upon learning of the exact nature of Patient D's injury on November 9, 1996;

2. Respondent failed to address the condition of Patient D's right lunate bone in his admission note upon Patient D's admission to Arden Hill Hospital on November 9, 1996;

3. Respondent failed to address the condition of Patient D's right median nerve in his admission note upon Patient D's admission to Arden Hill Hospital on November 9, 1996;

4. Respondent failed to adequately describe the condition of Patient D's wrist before and after the surgery of November 9, 1996;

5. Respondent failed to repair the injury of Patient D during his surgery of November 9, 1996;

6. Respondent failed to repair the injury of Patient D during his surgery of November 12, 1996;

7. Respondent inappropriately made a dorsal incision to repair a volarly dislocated lunate during his surgery of November 12, 1996;

8. Respondent failed to adequately describe the condition of Patient D's wrist before and after the surgery of November 12, 1996; and

9. Respondent failed to obtain a tomogram of Patient D's right wrist before December 24, 1996.

E. Respondent provided medical care and treatment to Patient E, a female patient 81 years old when treated for advanced osteoarthritis of the left hip with a left total hip replacement from on or about January 14, 2002 through on or about January 15, 2002 at Arden Hill Hospital in Goshen, New York. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent, after observing an error during surgery in the placement of the acetabular component that caused such instability of the hip that he informed the family of his concern immediately following surgery, failed to revise and/or record the revision of the acetabular component of Patient E's total hip replacement at a time when he had the best opportunity to correct the error.

F. Respondent provided medical care and treatment to Patient F, a male patient 69 years old when treated for advanced osteoarthritis of the right hip from on or about May 3, 1999 through on or about May 16, 1999 at Arden Hill Hospital in Goshen, New York. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately performed a bipolar hip replacement rather than the total hip replacement that had been planned and consented to preoperatively by Patient F;

2. Respondent falsely stated in his discharge summary that he replaced the acetabular component of Patient F's right hip;

3. Respondent failed to provide a basis in the record for converting the total hip replacement to a bipolar hip replacement;

4. Respondent failed to communicate to Patient F why he converted the total hip replacement to a bipolar hip replacement; and

5. Respondent inappropriately billed for a total hip replacement rather than a bipolar replacement.

G. Respondent provided medical care and treatment to Patient G, a female patient 38 years old when treated for a torn lateral meniscus in her left knee from on or about May 28, 1997 through on or about September 2, 1997 at his office in Goshen, New York and at Arden Hill Hospital in Goshen, New York. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately treated the post-operative positive culture for Staphylococcus Aureus in Patient G's left knee solely with an administration of the antibiotic Cipro; and

2. Respondent failed to treat and/or record Patient G's post-operative infection with an arthroscopic lavage, inpatient intravenous antibiotics and an Infectious Disease consultation.

SPECIFICATION OF CHARGES

FIRST 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 two or more of the following:

1. Paragraphs B. and B.1, C. and C.1, C. and C.2, D. and D.1, and/or D. and D.7.

SECOND THROUGH NINTH 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:

2. Paragraph A. and A.2
3. Paragraph B. and B.1;
4. Paragraph B. and B.2;
5. Paragraph C. and C.1;
6. Paragraph C. and C.2;
7. Paragraph C. and C.4;
8. Paragraph D. and D.1; and
9. Paragraph D. and D.7.

TENTH 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 two or more of the following:

10. Paragraphs A. and A.1, A. and A.2, B. and B.1, B. and B.2, C. and C.1, C. and C.2, C. and C.3, C. and C.4, D. and D.1, D. and D. 2, D. and D.3, D. and D.4, D. and D.5D C. and D.6, D. and D.7, D. and D.8, D. and D.9, E. and E.1, F. and F.1, F. and F.2, F. and F.3, F. and F.4, F. and F.5, G and G.1, and/or G. and G.2.

ELEVENTH THROUGH THIRTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

11. Paragraph A. and A.2;

12. Paragraph F. and F.2; and

13. Paragraph F. and F.5.

FOURTEENTH THROUGH FIFTEENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

14. Paragraph F. and F.2; and

15. Paragraph F. and F.5.

SIXTEENTH 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 care and treatment of the patient, as alleged in the facts of:

16. C. and C.2, C. and C.3, D. and D.2, D. and D.3, D. and D.4, D. and D.8, E. and E.1, F. and F.2, F. and F.3, and/or G. and G.2.

DATE: November 3, 2006
Albany, New York

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX II

Terms of Probation

Dr. Michael H. Kamalian's license to practice medicine in the State of New York shall be on probation for a period of eighteen (18) months.

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall enroll in and complete a continuing education program in the following areas; total hip joint surgery; medical record keeping; interpretation of radiological records. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the first year of probation.

9. Within thirty (30) days of the effective date of the Order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in orthopedic surgery, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection no less than 25% of records maintained by Respondent relating to open surgical procedures including patient records, prescribing information and office. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

   b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.