Public

STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 8, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Khalid Parwez, M.D.
59 River Street
Sidney, New York 13838

John T. Maloney, Esq.
Carter, Conboy, Case, Blackmore,
Maloney & Laird, P.C.
20 Corporate Woods Boulevard
Albany, New York 12211-2362

Jeffrey J. Conklin, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower – Room 2517
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Khalid Parwez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-217) 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of Khalid Parwez, 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. 09-217 COPY

Before ARB Members D'Anna, Wagle, Wilson and Milone[1]
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Jeffrey Conklin, Esq.
For the Respondent: John T. Maloney, Esq.

Following a hearing below, a BPMC Committee determined that the Respondent practiced medicine with gross negligence and gross incompetence in providing surgical care to two persons. The Committee voted to place a permanent limitation on the Respondent's license to practice medicine in New York State (License). In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2010), both parties ask that the ARB modify the Committee's Determination on the facts and on penalty. After reviewing the hearing record and the parties' submissions, the ARB affirms the Committee's Determination on the charges, but we overturn the Committee's Determination to limit the Respondent's License. The ARB votes instead to suspend the Respondent's License, to stay the suspension in full, to place the Respondent on probation and to order the Respondent to undergo retraining and then practice for a limited number of procedures with a physician present and assisting at surgery (preceptor).

[1] ARB Member Peter S. Koenig, Jr. did not participate in this case. The ARB proceeded to review the case with a four-member quorum, see Matter of Wolkoff v. Chassin, 89 N.Y.2d 250(1996).

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(3), 6530(4), 6530(5), 6530(6) and 6530(26) (McKinney 2010) by committing professional misconduct under the following specifications:

- practicing medicine with gross negligence,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross incompetence,
- practicing medicine with incompetence on more than one occasion, and,
- performing unauthorized professional services.

The charges related to the surgical care that the Respondent provided to seven persons (Patients A to G). The record refers to the Patients by initials to protect patient privacy. Following the hearing, the Committee rendered the Determination now on review.

The Committee dismissed all charges relating to Patients B, C, D, E and G and the Committee dismissed the charge that the Respondent performed unauthorized professional services. As relevant on this appeal, the Committee dismissed a charge that the Respondent failed to perform a timely Cesarean section on Patient D.

As to the care for Patient A, the Committee found that the Respondent operated on Patient A on January 30, 2002 to perform a hysteroscopy, laparoscopy and cystoscopy. The Respondent operated on the Patient again on March 13, 2002 to perform a total abdominal hysterectomy, bilateral salpingo-cophorectomy and cystoscopy. The Committee found that Patient had received treatment and medication for cardiac related problems and chest pain and that the standard of care required the Respondent to obtain a cardiac medical clearance for Patient A from a qualified cardiologist or internist prior to performing the January and March surgeries. The Respondent failed to obtain the clearance and the Committee determined that the failure posed life-threatening risks for the Patient, such as stroke, severe arrhythmia, myocardial infarction and congestive heart failure. The Committee concluded that the failure to obtain the clearance amounted to practicing with gross incompetence.

As to the care for Patient F, the Committee found that the Respondent operated on the Patient on November 23, 1998 to perform a hysterectomy, dilation and curettage and a laparoscopy. Anesthesia began at 8:35 a.m. During the laparoscopy, the Respondent transected the Patient's aorta on the right side and vena cava on the left side. At 9:05 a.m., during the surgery, the Patient's blood pressure was 148/86 and the Patient's pulse was 155. At 9:13 a.m., the Patient had no blood pressure and a thready pulse and a code blue was called. The Committee found that the standard of care required that the Respondent make a timely diagnosis as to the cause of the Patient's hypotension and to commence an exploratory procedure promptly and take appropriate action to stem the Patient's bleeding. The Committee found that the Patient lost 3500 cc's of blood during the surgery, an amount equal to the Patient's total blood volume. The Committee found that life-threatening risks to the Patient included profound shock, blood loss, pituitary failure, kidney failure, peripheral vascular failure problems secondary to a torn aorta, stenosis of the abdominal aorta and vena cava, bowel problems, injuries to the retroperitoneal space and retroperitoneal hematoma. The Committee found that the Respondent failed to perform a timely laparotomy and that another surgeon entered the operating room at 9:50 a.m. to perform a laparotomy to stop the Patient's bleeding. The Committee concluded that the Respondent's conduct amounted to practicing with gross incompetence.

In making their judgment to sustain or dismiss charges, the Committee relied on testimony by the Petitioner's expert, Joel S. Cooper, M.D., and the Respondent's expert, Robert H. Dropkin, M.D. Both physicians are board certified in obstetrics and gynecology. The Committee found the physicians equally credible, highly experienced and thoughtful and forthright in their testimony. The Committee found testimony by the Respondent evasive, argumentative and at times troubling. In making the findings concerning Patient A, the Committee accepted testimony by Dr. Cooper that the failure to obtain a clearance from a cardiologist or internist constituted a serious deviation from the standard of care that created a life-threatening risk of harm to Patient A. The Committee rejected contrary testimony from Dr. Dropkin because Dr. Dropkin assumed a series of contacts occurred between the Respondent and a cardiologist or internist. The Committee found that the medical record for Patient A provided

no support for such contacts. The Committee also rejected testimony from the Respondent that he himself made a sufficient assessment of risk to the Patient. The Committee noted that the Respondent testified to a fairly thorough understanding of the Patient's cardiac condition, but the Committee found no support for the testimony in the Respondent's record for Patient A. The Committee also credited testimony by Dr. Cooper that the standard of care required the Respondent to perform an exploratory procedure promptly to stop the bleeding in Patient F at the time a code was called for the Patient at 9:13 a.m. The Committee rejected contrary testimony from the Respondent and Dr. Dropkin as speculative at one point and as based on fabrication on another point.

The Committee voted to place a permanent restriction on the Respondent's surgical practice. The Committee found the Respondent failed to comprehend the serious need to obtain a clearance for surgery on Patient A from an internist or cardiologist. The Committee also found the Respondent lacked awareness concerning his own limitations in failing to respond to the code blue for Patient F. The Committee limited the Respondent's License to permit the Respondent to perform surgery only if another qualified surgeon is present in the operating room and prepared to perform surgery if necessary. The Committee concluded that allowing the Respondent to perform surgery without another qualified surgeon available would place the Respondent's patients at serious risk.

Review History and Issues

The Committee rendered their Determination on December 14, 2009. This proceeding commenced on December 21 and 24, 2009, when the ARB received first the Respondent's and then the Petitioner's Notices requesting 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 reply brief. The record closed when the ARB received the Respondent's reply brief on February 3, 2010.

The Petitioner's brief requested that the ARB overturn the Committee and sustain additional misconduct specifications concerning the care for Patients A and F. The Petitioner also alleged errors by the Committee in the findings concerning the care for Patient D. The Respondent asked that the ARB make additional findings of fact and that the ARB affirm misconduct specifications that the Respondent practiced with negligence and incompetence in performing a Cesarean section on Patient D. The Petitioner requested that the ARB affirm the limitation on the Respondent's practice that the Committee imposed, but also that the ARB suspend the Respondent's License, impose probation with monitoring and supervision and require a clinical assessment and a program of continuing medical education to address the deficiencies in the Respondent's practice.

The Respondent's brief challenged the Committee's conclusion that the Respondent lacked awareness of his own limitations in making the pre-operative assessment on Patient A. The Respondent argued that the facts in the case provided no justification for the findings as to Patient F and for the penalty the Committee imposed. The Respondent's brief asserted that that the Committee imposed too broad a limitation and the brief asked the ARB to modify the limitation to apply to only major surgeries. The Respondent's reply brief offered to accept a practice supervisor in lieu of the permanent restriction.

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' review submissions. The ARB rejects the requests from the parties that we make any changes to the Committee's findings of fact and conclusions on the charges. The ARB overturns the Committee's Determination to place a permanent restriction on the Respondent's License. The ARB votes 4-0 to suspend the Respondent's License, stay the suspension, place the Respondent on probation, order the Respondent to undergo retraining and limit the Respondent to practice with a preceptor for a limited number of procedures following the retraining.

The Petitioner requested that the ARB overturn the Committee's Determination concerning the Cesarean section on Patient D. The Committee dismissed Factual Allegation D.1 that alleged the Respondent failed to appropriately and/or timely perform the Cesarean section. The Committee's Finding of Fact 51 found specifically that the Respondent ordered and performed a timely C-section on Patient D. The Petitioner's brief at pages 11-12 argued that evidence appeared in the record that contradicted the Committee's Determination and the Petitioner asked that the ARB make factual findings that would provide the basis for sustaining Factual Allegation D.1. The ARB rejects that request. Under PHL §§ 230(10)(g) and 230-c, a hearing committee makes findings of fact and the ARB reviews those findings. No provision in PHL § 230-c authorizes the ARB to make separate findings from the Committee.

The Respondent challenged the Committee's findings on the failure to obtain medical clearance on Patient A to the extent that the finding influenced the Committee's Determination on penalty (Respondent's brief page 3) and the Respondent challenged the Committee's findings concerning the failure to respond appropriately to the code for Patient F. The Respondent's challenges argue that other evidence in the record conflicts with the Committee's finding. The

ARB finds that the Committee discussed such evidence in making their conclusions. The Respondent testified that he made a sufficient assessment on Patient A himself and the Respondent's expert based his testimony on assumed contacts between the Respondent and other physicians. The Committee found the Respondent's testimony non-credible and the Committee found the Respondent's medical record for the Patient did not support contact with other physicians immediately prior to the two surgeries on Patient A. The Committee also found the Respondent lacked credibility in his testimony on Patient F and found the Respondent fabricated one answer to justify his failure to take prompt action. The ARB defers to the Committee as the fact-finder in making judgments on credibility. The Committee found Dr. Cooper credible in his testimony that the accepted standard of care required that the Respondent obtain another physician's cardiac clearance on Patient A and that the Respondent perform promptly an exploratory procedure to stop the bleeding in Patient F. The testimony by Dr. Cooper also provided the evidence for the Committee to find that the failure to obtain the clearance and perform the prompt procedure placed Patients A and F at risk for life-threatening conditions. The evidence the Committee found credible demonstrated that the Respondent practiced with gross negligence in treating Patient A and gross incompetence in treating Patient F

The ARB overturns the Committee's Determination to limit the Respondent's License permanently to prohibit the Respondent from performing surgery unless another qualified physician is present in the operating room and prepared to perform the surgery if necessary. The Respondent called the penalty overly broad. The ARB finds the penalty impractical. The Respondent's main errors came in preparation for the surgery for Patient A and in the Respondent's response to complications in the surgery for Patient F. The ARB concludes that a

penalty shorter in duration and more narrow in scope will address the Respondent's deficiencies and protect the public.

The ARB orders that the Respondent attend and complete a course on laparoscopic procedures and the procedures' complications. This should be a substantive course of multiple days in duration, rather than hours, and it should include a "hands on" element. The Director of the Office of Professional Medical Conduct (OPMC) must approve the course. The ARB prohibits the Respondent from performing laparoscopic procedures until the Respondent completes the course. For the first twenty-five laparoscopic procedures following the course's completion, the Respondent may perform the procedures only with a preceptor present and assisting with the surgery. The preceptor must review pre-operative evaluations and assessments. No patient shall be responsible for the any cost related to the preceptor. The ARB set the preceptor requirement for a specific number of procedures, rather than for a specific time-frame, as a way to assure that the Respondent will actually perform procedures with a preceptor.

The ARB votes to suspend the Respondent's License for two years. We find a suspension appropriate because the Respondent engaged in acts of gross misconduct that placed patients at risk for life-threatening conditions. The ARB stays the suspension in full, because we conclude that the other provisions in this penalty will provide protection to the public. The ARB places the Respondent on probation for two years under the terms that appear in the Appendix to this Determination. The terms include a practice monitor. The practice monitor and the preceptor may be the same physician, but the ARB does not require that the same physician should perform both functions.

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 gross negligence in treating Patient A and with gross incompetence in treating Patient F.
2. The ARB overturns the Committee's Determination to place a permanent limitation on the Respondent's License.
3. The ARB suspends the Respondent's License for two years, stays the suspension and places the Respondent on probation for two years, under the terms that appear as the Appendix to this Determination.
4. The ARB bars the Respondent from performing any laparoscopy procedures until the Respondent completes retraining as the ARB specified in this Determination.
5. For the first twenty-five laparoscopies the Respondent performs after completing that retraining successfully, the Respondent must perform the procedures with another physician (preceptor) present and assisting with the surgeries.

Datta G. Wagle, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

Appendix

Terms of Probation

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

2. The Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. The Respondent shall submit written notification to the Board, addressed to the Director of OPMC, 433 River Street, Suite 303, Troy, New York 12180-2299 regarding any change in employment, practice, address, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. The Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. The period of probation shall be tolled during periods in which the Respondent is not engaged in the active practice of medicine in New York State. The Respondent shall notify the Director of OPMC in writing, if the 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. The 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 the Respondent's return to practice in New York State.

6. The Respondent shall maintain legible and complete hospital and office medical

records, which accurately reflect evaluation and treatment of patients. All hospital and office medical records shall contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record shall contain all information required by state rules and regulations regarding controlled substances.

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

8. The Director of OPMC may review the Respondent's professional performance. 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 the Respondent, his staff at locations or OPMC offices.

9. The Respondent shall practice medicine only when monitored by a licensed physician, board certified in the appropriate specialty (practice monitor), proposed by the Respondent and subject to the written approval of the Director of OPMC.

a. The Respondent shall make available to the monitor any and all records and access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit the Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by the Respondent, including patient records, prescribing information and

office records. 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 from the accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

d. The 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 PHL § 230(18)(b). Proof of coverage shall be submitted to the Director of OPMC prior to the Respondent's practice after the effective date of this Order.

10. The Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against the Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.

In the Matter of Khalid Parwez, M.D.

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

Dated: June, 2010

REDACTED

Linda Prescott Wilson

In the Matter of Khalid Parwez, M.D.

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

Dated: 6/7/, 2010

REDACTED

Datta G. Wagle, M.D.

In the Matter of Khalid Parwez, M.D.

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

Dated: June 7, 2010

REDACTED

Richard D. Milone, M.D.

In the Matter of Khalid Parwez, M.D.

John A. D'Anna, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Parwez.

Dated: Jun 7th, 2010

REDACTED

John A. D'Anna, M.D.