STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

December 12, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin P. Donovan, Esq.
NYS Department of Health
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237

Momtaz Ahmed, M.D.
5813 Independence Drive
Jamesville, New York 13078

Joseph Cote, Esq.
Suite 501
Empire Building
472 South Salina Street
Syracuse, New York 13202

Momtaz Ahmed, M.D.
472 South Salina Street
Syracuse, New York 13202

RE: In the Matter of Momtaz Ahmed, M.D.

Dear Mr. Donovan, Mr. Cote and Dr. Ahmed:

Enclosed please find the Determination and Order (No. BPMC-96-293) 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.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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.

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

MOMTAZ AHMED, M.D.

DETERMINATION

AND

ORDER

BPMC-96-293

MS. MARYCLAIRE B. SHERWIN, Chairperson, **ANDREW J. MERRITT, M.D.** and **STANLEY D. LESLIE, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this DETERMINATION AND ORDER.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	August 15, 1996
Pre-Hearing Conference:	September 26, 1996
Hearing Dates:	October 16, 1996 November 6, 1996
Place of Hearing:	NYS Department of Health 217 South Salina Street Syracuse, New York
Date of Deliberations:	December 4, 1996

Petitioner Appeared By:

Henry M. Greenberg, Esq.,
General Counsel
NYS Department of Health
By: Kevin P. Donovan, Esq.

Respondent Appeared By:

Joseph Cote, Esq.
Suite 501
Empire Building
472 South Salina Street
Syracuse, New York 13202

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Moral Unfitness; Patient Abuse; Gross Incompetence; Gross Negligence and Failure to Maintain Adequate Patient Records.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

WITNESSES

For the Petitioner:

1) Patient A
2) Patient A's Husband
3) Alan La Flore
4) Lothar Wertheimer, M.D.

For the Respondent:

1) Andrew Knoll, M.D.
2) Momtaz Ahmed, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Momtaz Ahmed, M.D., the Respondent, was authorized to practice medicine in New York State on February 26, 1970, by the issuance of license number 105545 by the New York State Education Department (Pet's. Ex. 2).

FINDINGS AS TO PATIENT A

2. Patient A was a 22 year old female on September 15, 1993, when she went to Syracuse Community Health Center (SCHC) for a physical examination which was required for her entry into a nursing program (Pet's. Ex. 3, pp. 2-5, 11; Tr. 19-20).

3. Patient A had been to SCHC on previous occasions for dental and ob/gyn appointments and was not nervous or concerned about this examination (Tr. 20).

4. Patient A drove with her husband from home to SCHC. She brought with her forms on which she had already completed identifying information and medical history (Pet. Ex. 3, pp. 2-3; Tr. 21).

5. A nurse brought her to an examining room and her vital signs were taken. Patient A's blood pressure on September 15, 1993, as noted in the SCHC flow sheet, was 130/100 (Pet's. Ex. 3, p. 11; Tr. 22).

6. The nurse asked her to change into an examining gown and leave on her underclothes. The nurse then left. While she was changing, the Respondent walked into the room without knocking. She had already removed her outer clothes but had not yet put on her gown. The Respondent stood and watched her as she finished getting dressed for the examination (Tr. 22-23).

7. The Respondent did not ask Patient A any questions about her family history; specifics about her kidney stones; her blood pressure; her history concerning breast problems or a family history of breast problems, or why she was there (Tr. 24-25).

8. The Respondent examined Patient A's eyes, ears and mouth (Tr. 25).

9. The Respondent then pulled down Patient A's examining gown while she was sitting on the edge of the table. He touched her breasts while she was still wearing her brassiere. He squeezed her breasts simultaneously with both of his hands, with his thumbs on the bottom of her breasts and his fingers on the top. He did not move his hands and fingers in a circular motion (Tr. 25-26).

10. The Respondent then used the stethoscope on her chest, stomach and back (Tr. 26-27).

11. While Respondent had the stethoscope on the Patient's back, he put his right hand on her right breast, which was still covered with her brassiere (Tr. 27).

12. The Respondent never explained to Patient A what he was doing while he was squeezing her breasts nor did he make any comments to her about any findings he made concerning her breasts (Tr. 27).

13. Following these occurrences, the Respondent asked the patient to lay on her back on the table. He felt her abdomen and then he pulled her underwear down. He separated her labia and asked her to cough (Tr. 28-29).

14. There was no screen between her face and his. She could see his face and saw that he was looking at her labia, her genitals. He asked her to cough a couple times (Tr. 28-29).

15. The Respondent made no comments to Patient A while he was performing this genital inspection nor did he report any findings to her (Tr. 29).

16. The Respondent then pulled Patient A's underwear up, told her to get dressed, and he left her (Tr. 29).

17. Since Patient A was 13 or 14 years old, physicians have commented to her that her breasts are cystic fibrotic (Tr. 30).

18. The Respondent wrote in Patient A's medical record that she was within normal limits (Pet's. Ex. 3, p. 2; Tr. 119).

19. The Respondent admitted during an interview with OPMC investigator, Alan LaFlore, that he performed the breast examination of the patient with her brassiere on. He also stated that he visually inspected the patient's vaginal area for lesions and for hernia (Tr. 75).

20. Patient A's mother and grandmother both have a history of breast problems, namely cystic fibrotic breasts. Her mother had a tumor removed from her breast when she was 18 years old (Tr. 30).

21. Prior to this examination, the patient had many physical examinations and breast examinations (Tr. 31).

22. The Respondent's breast examination was different than any other Patient A ever had. The prior examinations involved removal of her brassiere and having her lay back on a table while the physician would feel her breasts using a circular motion, one breast at a time (Tr. 31-32).

23. When Patient A left SCHC, she rode home with her husband, a 15 to 20 minute drive. She did not tell her husband what had occurred because she usually does not tell him when something is wrong (Tr. 32).

24. When she arrived home, she called her mother to tell her that she was uncomfortable with the physical exam. She also called Family Planning Service, where she had also received medical care, and asked to speak to a counselor because she was uncomfortable with the physical. The patient's call to the Family Planning Service was noted in her chart. The counselor told her that she should contact the Director of SCHC since she felt the physical was wrong (Pet's. Ex. 4A, p. 13; Tr. 32-34).

25. Patient A wrote a letter to the Director of SCHC, and in response SCHC requested her to come in and she complied. At SCHC, Patient A made a statement which was typed by SCHC staff, and she signed it (Pet's. Ex. 6; Tr. 34-35).

26. Patient A's interaction with the Respondent affected her relationship with her husband. She stopped being sexually intimate with him and slept with her clothes on because she did not like being touched. This caused a brief separation of the couple. Prior to her visit with the Respondent, their sexual relations had been fine (Tr. 36, 68).

27. Patient A has never made a complaint about any other physician (Tr. 36).

28. When Patient A initially arrived at SCHC on September 15, 1993 her blood pressure was recorded as 130/100 and the Respondent noted it as normal. It is not within acceptable standards to note vital signs being normal when a patient has a blood pressure of 130/100 (Pet's. Ex. 3, p. 2; Tr. 120).

29. When the Respondent was confronted with this elevated blood pressure, acceptable standards of care require that he should have taken the blood pressure a second time and he should have recorded it. A repeat blood pressure was not recorded in this instance. Another physician reviewing this record would get the impression that everything was normal with this patient (Pet's. Ex. 3, p. 2; Tr. 122-124).

30. Since this patient had an elevated blood pressure, the Respondent should have inquired if there was a family history of hypertension. He failed to do so (Tr. 147-148).

31. The Respondent's medical records for Patient A do not meet acceptable standards (Tr. 208-209).

32. The Respondent's physical examination of Patient A was also inappropriate because he was touching the patient's right breast while listening to lung sounds. When performing such an examination, the physician needs to concentrate on the lung sounds (Tr. 160).

33. The Respondent's examination of the patient's genitalia did not meet acceptable medical standards. It is not necessary to spread the labia to check for hernia. While there are various types of hernias, umbilical, inguinal, and femoral, none of them require separating the labia (Tr. 161).

CONCLUSIONS OF THE HEARING COMMITTEE

On September 15, 1993, Patient A went to the Syracuse Community Health Center (SCHC) for what was essentially a routine school physical examination, and the Respondent performed the examination in a hasty, careless, negligent manner.

Based on the entire record in this matter, the Hearing Committee concludes as follows:

1. The Respondent failed to obtain and/or record an adequate medical history of Patient A, including family and present history, and history regarding hypertension and breast problems.

2. The Respondent failed to perform and/or record an adequate physical examination and/or evaluation of Patient A, including her breasts, lungs, heart, and/or vital signs.

3. The Respondent's examination of Patient A's breasts and labia were not appropriate and did not meet the minimum acceptable standards of medical practice.

4. There is no evidence in the record to support a charge of Gross Incompetence.

5. There is no evidence in the record that the Respondent's examination of Patient A's breasts and labia were for his own sexual gratification. Granted that the examinations were not appropriate and did not meet the minimum acceptable standards of medical practice, there was no touching in a sexual manner, the Respondent did not ask the patient to remove her brassiere and there is no evidence whatsoever that he exhibited any behavior indicating that he was seeking sexual gratification. On the contrary, the Hearing Committee got the distinct impression that the examinations were conducted in a hurried, careless, "Let's get this thing over with" attitude on the part of the Respondent.

6. The Patient's blood pressure was clearly abnormal on the flow sheet and the Respondent's failure to record a repeat blood pressure was a significant deviation from the minimum acceptable standards of medical practice.

The Respondent's failure to obtain and/or record an adequate medical history of Patient A and his failure to perform and/or record an adequate physical examination and/or evaluation of Patient A, constitute multiple acts of negligence that cumulatively amount to egregious conduct and constitute gross negligence.

VOTE OF THE HEARING COMMITTEE

FIRST SPECIFICATION: Moral Unfitness

NOT SUSTAINED (Vote 3-0)

SECOND SPECIFICATION: Patient Abuse

NOT SUSTAINED (Vote 3-0)

THIRD SPECIFICATION: Gross Incompetence

NOT SUSTAINED (Vote 3-0)

FOURTH SPECIFICATION: Gross Negligence

SUSTAINED (Vote 3-0)

FIFTH SPECIFICATION: Inadequate Records

SUSTAINED (Vote 3-0)

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee determines that the Respondent's license to practice medicine in New York State should be **SUSPENDED** for a period of one (1) year, **SUSPENSION STAYED** and the Respondent be put on probation for a period of six (6) months subject to the conditions hereinafter specified in the Hearing Committee's **ORDER.**

ORDER

THEREFORE IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for a period of one (1) year, **SUSPENSION STAYED** and the Respondent is put on probation for a period of six (6) months from the effective date of this **ORDER**, subject to the following conditions:

i) The Respondent shall, within 4-6 weeks of the effective date of this **ORDER**, attend a SUNY Health Science Center Breast Clinic and perform supervised breast examinations. The supervising physician at the breast clinic shall notify the Office of Professional Medical Conduct when the Respondent has demonstrated the ability to perform breast examinations that conform with acceptable standards of medical practices.

ii) The medical records prepared by the Respondent at the Syracuse Community Health Center shall be monitored monthly by the Medical Director of the facility to insure that they adequately reflect the care and treatment of the patients. The Medical Director shall file a monthly report with the Office of Professional Medical Conduct reporting on the Respondent's compliance with maintaining records which meet acceptable standards of medical practice.

iii) Whenever the Respondent examines a female patient, a chaperon must be present.

2. This **ORDER** shall be effective upon service on the Respondent or his attorney by personal service or by certified or registered mail.

DATED: 12/10/96

MS. MARYCLAIRE B. SHERWIN, Chairperson

ANDREW J. MERRITT, M.D.
STANLEY D. LESLIE, M.D.

TO: Kevin P. Donovan, Esq.
NYS Department of Health
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Joseph Cote, Esq.
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472 South Salina Street
Syracuse, New York 13202

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
MOMTAZ AHMED, M.D.	:	CHARGES

----------X

MOMTAZ AHMED, M.D., the Respondent, was authorized to practice medicine in New York State on February 26, 1970, by the issuance of license number 105545 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Patient A (the patient is identified in Appendix A), a 22 year old female, presented to Respondent at Syracuse Community Health Center, Syracuse, New York, on or about September 15, 1993, for a history and physical examination. Respondent failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or record an adequate history of Patient A, including family and present history, and history regarding hypertension and/or breasts.

2. Respondent failed to perform and/or record an adequate physical examination and/or evaluation of Patient A, including her breasts, lungs, heart, and/or vital signs.

3. Respondent simultaneously placed both of his hands on Patient A's breasts over her brassiere, which was not medically justified.

4. Respondent, while holding a stethoscope on Patient A's back, placed his hand on Patient A's right breast over her brassiere, which was not medically justified.

5. Respondent spread Patient A's labia, and/or looked at her genitalia for an excessive period of time, which was not medically justified.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

MORAL UNFITNESS

The Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of N.Y. Education Law § 6530(20) (McKinney Supp. 1996), in that Petitioner charges:

1. The facts of paragraphs A and A.3, A and A.4 and/or A and A.5.

SECOND SPECIFICATION

PATIENT ABUSE

Respondent is charged with willfully physically abusing a patient within the meaning of New York Education Law § 6530 (31) (McKinney Supp. 1996), in that Petitioner charges:

2. The facts of paragraphs A and A.3, A and A.4, and/or A and A.5.

THIRD SPECIFICATION

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of New York Education Law § 6530(6) (McKinney Supp. 1996), in that Petitioner charges:

3. The facts in paragraphs A and A.1 and/or A and A.2.

FOURTH SPECIFICATION

GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of New York Education Law § 6530(4) (McKinney Supp. 1996), in that Petitioner charges:

4. The facts of paragraphs A and A.1 and/or A and A.2.

FIFTH SPECIFICATION

INADEQUATE RECORDS

The Respondent is charged with failure to maintain a record which accurately reflects his evaluation and treatment of a patient within the meaning of New York Education Law § 6530(32) (McKinney Supp. 1996), in that Petitioner charges:

5. The facts of paragraphs A and A.1 and/or A and A.2.

DATED: August 15, 1996
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct