Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

April 5, 2013

CORRECTED COPY OF DETERMINATION AND ORDER

Robert Cattani, M.D.
450 Slosson Avenue
Staten Island, New York 10314

Michael J. Morris, Esq.
Costello, Shea & Gaffney, LLP
44 Wall Street
New York, New York 10005

Dianne Abeloff, Esq.
NYS Department of Health
Division of Legal Affairs
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Robert Cattani, M.D.

Dear Parties:

Enclosed please find a corrected copy of the Determination and Order (No. 13-95) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. **The first sentence in the second full paragraph on page 2 should say abdominoplasty instead of angioplasty.** 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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
Riverview Center
150 Broadway – Suite 355
Albany, New York 12204

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

REDACTED

James F. Horan /
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of

Robert Cattani, 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. 13-

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

For the Department of Health (Petitioner): Dianne Abeloff, Esq.
For the Respondent: Michael J. Morris, Esq.

Following a hearing below, a BPMC Committee sustained charges that the Respondent committed professional misconduct in treating four patients. The Committee voted to revoke 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 2013), the Respondent asks the ARB to nullify the Committee's Determination or, in the alternative, to overturn the revocation and impose a less severe penalty. After reviewing the hearing record and the review submissions, the ARB votes 3-1 to affirm the Committee's Determination in full.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(3-5) and 6530(32)(McKinney Supp. 2013) by committing professional misconduct under the following specifications:

- practicing with negligence on more than one occasion,
- practicing with gross negligence,

[1] ARB Member John D'Anna, M.D. recused himself from participating in this case. The ARB proceeded to review the case with a four-member quorum, Wolkoff v. Chassin, 89 N.Y.2d 250 (1996).

- practicing with incompetence on more than one occasion, and,
- failing to maintain accurate patient records.

The charges related to the care that the Respondent, a surgeon, provided to five persons (Patients A-E). The record refers to the patients by initials to protect privacy. Following the hearing on the charges, the Committee rendered the Determination now on review.

The Committee dismissed all allegations and charges relating to the care for Patient E. The Committee sustained the charges that the Respondent practiced with negligence on more than one occasion, gross negligence and incompetence on more than one occasion in treating Patients A-D. The Committee also sustained the charges that the Respondent failed to maintain accurate patient records relating to the care for Patients A-D.

The Respondent performed an abdominoplasty, or liposuction, on Patient A. The Committee found that the Respondent exercised extremely poor judgment to even consider such surgery on the Patient, who was only 20 year old, with skin that was still elastic. The Patient suffered extensive external bleeding following the surgery. The Committee found that the Respondent failed to address the bleeding and the Patient's lack of urination. The Committee found that a physician must monitor fluid intake and output to ascertain whether a patient's kidneys are working. The Respondent also resisted the Patient's requests for transfer to a hospital and instead the Respondent recommended that the Patient go to a hotel. The Respondent eventually called Faiz Hasham, M.D., the anesthesiologist, who attended Patient's A's surgery, to return to the Respondent's office. Dr. Hasham administered ephedrine, which caused only a temporary rise in blood pressure, but did nothing about the Patient's bleeding. The Respondent finally transferred the Patient to a hospital after an episode in which the Patient fell back onto a table with a thud and after cajoling from a team of emergency medical technicians who came to the Respondent's office in response to a call from a friend of Patient A. At Staten Island University Hospital, Patient A received three units of packed red blood cells and the Patient stayed in the Hospital for nine days. The Respondent's medical expert, Richard Dolsky, M.D., conceded that Patient A's condition presented all the components of hypovolemic shock. The Committee found that the Respondent failed to maintain an accurate record for Patient A,

because the Respondent recorded the Patient's blood pressure as stable, while a medical assistant made entries in the same record that showed the Patient's blood pressure dropping.

The Respondent performed an abdominoplasty or tummy tuck on Patient B. The Committee found that the Respondent showed poor judgment in making the incision for the tummy tuck in an area already compromised by complications from an earlier procedure. The Committee noted that the skin in the compromised area was very thin and susceptible to perforation. The Respondent perforated the abdomen during the tummy procedure. Several days after surgery, in response to pain and discomfort, Patient B removed the abdominal binding and saw feces pouring out of his abdomen. The Patient called the Respondent immediately. The Respondent failed to send the Patient to a hospital that day and instead told the Patient to come to the Respondent's Office the following day. Upon seeing the Patient the following day, the Respondent again failed to send the Patient to a hospital and, instead, the Respondent referred the Patient to the Patient's primary treating physician. The primary treating physician transferred the Patient to a hospital immediately. The Committee found that the Respondent failed to maintain accurate records for Patient B. The Committee found that entries the Respondent made in the Patient's medical record differed from the Patient's version of the events and the Committee found the Patient's version credible. For example, the Respondent recorded that the Patient was not in pain, but the Patient testified that he was in excruciating pain. The record also indicated that the Respondent offered to see the Patient on the same day as the Patient first contacted the Respondent about feces leaking from the Patient's abdomen. The Patient denied that he was offered the chance to see the Respondent that same day.

The Respondent performed a four lid blepharoplasty (eyelid lift) on Patient C. The Committee found that every physician must know that such a procedure can result in a retrobulbar hematoma or bleeding that places pressure on the optic nerve. This bleeding is a medical emergency that requires quick repair or the optic nerve can die and blindness ensue. The Committee found that a physician must make a prompt diagnosis by looking into the eyes. If there is a significant difference in the eyes or if a patient is unable to see out of one eye, the physician must release pressure on the eye by performing a canthotomy. The Committee found

that the Respondent released Patient C from the recovery room prematurely and that the Respondent failed to examine the Patient's eyes after surgery. The Committee found that the Patient's right eye was quite swollen and that the Patient was still unable to see in the lower fields of the eye three days past surgery. The Respondent made no attempt to release pressure on the eye or transfer the Patient to a hospital at that time. The Committee found that the Respondent failed to maintain an accurate record for Patient C. The Committee determined that the record stated falsely that the Respondent examined the Patient post-operatively and that the Patient could see well out of both eyes.

The Respondent performed breast augmentation surgery on Patient D in 2000 and 2010. The Patient is a controlled diabetic and experienced no problems with healing after the 2000 procedure. The Committee found that the Patient experienced excruciating pain, as well as redness and inflammation in the Patient's left breast from the time the Patient returned home on the day of the 2010 surgery. The Committee found that the Respondent failed to examine the Patient within the first few days after surgery and that the Respondent failed to respond himself to numerous calls from the Patient and the Patient's mother. The Committee found that the Respondent failed to maintain accurate records for Patient D. The Committee found further that the Respondent's records contained glaring inaccuracies and false statements. The Committee concluded that the Respondent fabricated the record for his own purposes.

In making their findings, the Committee relied heavily on testimony from the Department's expert witness, Barry Zide, M.D. The Committee found Dr. Zide's credentials outstanding and the Committee noted that Dr. Zide is the author of relevant medical textbooks. The Committee also found that Dr. Zide reviewed more evidence and possessed more expertise than the Respondent's expert witness, Richard Dolsky, M.D. The Committee found Dr. Dolsky less credible and less persuasive than Dr. Zide. The Committee also described Dr. Dolsky's testimony as not forthcoming and evasive. The Committee found the Respondent's testimony false and self-serving and also found the Respondent had every reason to testify inaccurately and to author inaccurate records. The Committee found the testimony by Dr. Hasham, the anesthesiologist who treated Patient A, to be self-serving and unreliable.

The Committee voted to revoke the Respondent's License pursuant to their authority under PHL § 230-a(4). The Committee stated that the injuries at issue in the case were preventable and the injuries showed serious flaws in judgment that no manner of retraining could remedy. The Committee discussed limiting the Respondent's License to minor surgery, but concluded that emergencies can arise even with minor procedures. The Committee indicated they did not trust the Respondent's judgment to deal with an emergency.

Review History and Issues

The Committee rendered their Determination on September 11, 2012. This proceeding commenced on September 24, 2012, when the ARB received the Respondent's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's reply brief. The ARB extended the Respondent's time to file the review brief on several occasions due to difficulties in the office of the Respondent's counsel following super storm Sandy. The Respondent filed his brief on January 29, 2013.

The Respondent argued that bad results do not mean there was a deviation from the standard of care. The Respondent argued that the Respondent failed to receive effective assistance of counsel, that the evidence failed to support the Committee's findings and that the Committee imposed an overly harsh penalty.

The Petitioner answered that the Respondent is not entitled to a new hearing in this case based on the argument that the Respondent made concerning ineffective assistance of counsel. The Petitioner stated further that the Respondent's other contentions repeated arguments that the Respondent made at hearing and that the Committee rejected.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only

pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. The ARB votes 3-1 to affirm the Committee's Determination that the Respondent committed professional misconduct and to affirm the Committee's Determination revoking the Respondent's License.

The ARB majority rejects the Respondent's request to nullify the Committee's decision on grounds relating to assistance of counsel. The ARB notes that a decision to annul a disciplinary decision for legal error lies with the courts, Freidel v. Board of Regents, 296 N.Y. 347 (1947). As we noted above, an ARB review considers 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. Under our authority at PHL § 230-c(4)(b), the ARB may remand a case to "the committee for further proceedings". The ARB votes 3-1 against remanding this case for further proceedings and the majority leaves the Respondent to raise his procedural arguments with the courts. One ARB Member would remand.

The Respondent's brief contended that the evidence failed to support the Committee's findings. The majority rejects that argument as well. The evidence the Committee found credible, from the expert testimony by Dr. Zide to the factual testimony by Patients A-D and other Petitioner's witnesses present during the events at issue, proved the charges that the Respondent practiced with gross negligence, with negligence and incompetence on more than one occasion

and that the Respondent failed to maintain accurate patient records. The Respondent presented evidence to challenge the charges, such as his own testimony and testimony from other physicians. The Committee gave extensive reasons why they credited the testimony by Dr. Zide and the Patients and why the Committee found the Respondent and his witnesses lacked credibility. The ARB defers to the Committee as the fact finders in their judgment on credibility. The majority finds that the Committee's Determination is consistent with the findings and conclusions that the Respondent practiced with gross negligence and with negligence and incompetence on more than one occasion and that the Respondent failed to maintain accurate patient records.

The ARB votes 3-1 to affirm the Committee's Determination to revoke the Respondent's License. The majority was troubled by the Respondent's basic medical errors and by the appalling errors in judgment. Some of the Patients escaped death only by luck or divine providence. The Committee considered limiting the Respondent's License to performing minor procedures such as hair restoration. The Committee rejected such a limitation because emergencies can arise, even with minor procedures. The ARB majority agrees with the Committee that we do not trust the Respondent's judgment to deal with an emergency. The majority also agrees with the Committee that the Respondent demonstrated flaws in judgment and insight that no retraining could remedy. The AB majority concludes that we can protect patient safety only by removing the Respondent from practice.

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 committed professional misconduct.
2. The ARB affirms the Committee's Determination to revoke the Respondent's License.

Peter S. Koenig, Sr.
Datta G. Wagle, M.D.
Linda Prescott Wilson
Richard D. Milone, M.D.

In the Matter of Robert Cattani, M.D.

Linda Prescott Wilson, an ARB Member, confirms that she took part in this case and that this Determination reflects the decision of the ARB majority in the Matter of Dr. Cattani.

Dated: [redacted], 2013

REDACTED

Linda Prescott Wilson

In the Matter of Robert Cattani, M.D.

Peter S. Koenig, Sr., an ARB Member, confirms that he took part in this case and that this Determination and Order reflects the decision of the ARB majority in the Matter of Dr. Cattani.

Dated: April 3, 2013

REDACTED

Peter S. Koenig, Sr.

In the Matter of Robert Cattani, M.D.

Datta G. Wagle, M.D., an ARB Member, confirms that he took part in this case and that this Determination and Order reflects the decision of the ARB majority in the Matter of Dr. Cattani.

Dated: March 19, 2013

REDACTED

Datta G. Wagle, M.D.

In the Matter of Robert Cattani, M.D.

Richard D. Milone, an ARB Member, confirms that he took part in this case and that this Determination and Order reflects the decision of the ARB majority in the Matter of Dr. Cattani.

Dated: April 3, 2013

REDACTED

Richard D. Milone, M.D.