PUBLIC

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

October 1, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Andrea Schillaci, Esq.
Hurwitz & Fine, P.C.
424 Main Street
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Buffalo, New York 14202

Tariq Niaz Ahmad, M.D.

Redacted Address

RE: In the Matter of Tariq Niaz Ahmad, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-13) 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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
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 Signature

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:nm

Enclosure

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

In the Matter of

Tariq Niaz Ahmad, 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. 12-13

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

For the Department of Health (Petitioner): Timothy J. Mahar, Esq.
For the Respondent: Andrea Schillaci, Esq.

After a hearing below, a BPMC Committee found that the Respondent failed to follow accepted care standards in treating patients and that the Respondent failed to maintain appropriate patient records. The Committee voted to suspend the Respondents' License to practice medicine in New York State (License), to stay the suspension, to limit the Respondent's License and to place the Respondent on Probation under the Probations Terms that appear at Attachment A to the Committee's Determination. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2012), both parties ask the ARB to nullify or modify the Committee's Determination. After reviewing the hearing record, the ARB affirms the Committee's Determination on the charges and the penalty, except that we overturn the limitation on the Respondent's License, we amend a provision in the Committee's Order and we amend two paragraphs in the Probation Terms.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(2-6), 6530(20-21) & 6530(32) (McKinney 2012) by committing professional misconduct under the following Specifications of Misconduct (Specifications):

- practicing the profession fraudulently [Nineteenth and Twentieth Specifications],
- practicing the profession with negligence on more than one occasion [Eighteenth Specification],
- practicing the profession with gross negligence [Specifications One through Eight],
- practicing the profession with incompetence on more than one occasion [Seventeenth Specification],
- practicing the profession with gross incompetence [Specification Nine through Sixteen],
- engaging in conduct that evidences moral unfitness [Thirty-Second through Thirty-Third Specifications],
- willfully filing a false report [Twenty-First and Twenty-Second Specifications], and,
- failing to maintain accurate patient records [Twenty-Third through Thirty-First Specifications].

The Statement of Charges [Appendix I to Committee Determination] related to the care the Respondent provided to nine persons (Patients A-I) at Mercy Hospital in Buffalo (Mercy) and at Absolut of Aurora Park (Absolut), a skilled nursing facility in Aurora Park, New York. The fraud, false report and moral unfitness charges related solely to the Respondent's entries in the medical chart for patient B. The record refers to the Patients by initials to protect privacy. The Committee conducted a hearing into the charges and rendered the Determination now on review.

The Committee sustained the charges that the Respondent practiced with gross negligence in treating Patient A. The Committee also sustained charges that the Respondent

practiced with negligence on more than one occasion in treating all Patients A-I. The Committee also sustained charges that the Respondent failed to maintain accurate records for Patients A, B, C, F and I. The Committee dismissed the remaining record charges and dismissed all incompetence, gross incompetence, moral unfitness, fraud and false record charges.

The Committee found that the Patient A presented at risk for blood clots due to a mechanical heart valve. Tests upon Patient A on admission to Mercy revealed an increased risk for clots. The Committee found that the accepted medical practice required that the Patient receive an appropriate dose of the fast acting blood thinning medication, Lovenox. The Committee found further that the Respondent ordered an inadequate dose for a person of the Patient's size and weight, that the Patient developed a clot during surgery and that the Patient died. The Respondent then drafted a post-surgery note that showed improvement in the deceased Patient and the Patient's discharge. The Committee concluded that the Respondent's conduct amounted to practicing with gross negligence and with failing to prepare an accurate patient record. The Committee found that the Respondent practiced with negligence by failing to document progress notes for Patient B for three straight days in April 2007 and that the Respondent failed to maintain accurate patient records by then back dating progress notes into that Patient's chart. The Committee concluded that the back dating showed carelessness by the Respondent, but found that the Respondent's conduct failed to amount to willful or intentional attempts to deceive. The Committee, therefore, dismissed the charges that the back dating amounted to fraud, willfully filing a false report or engaging in conduct that evidences moral unfitness. The Committee found further that the Respondent practiced with negligence on more than one occasion by:

- failing to order anti-coagulant therapy for Patient C, despite the Patient's increased risk for stroke and prescribing a contra-indicated medication at discharge;
- failing to respond to hospital pages concerning Patient D over a period of 84 minutes;
- failing to respond, over a 69 hour period, to calls from the nursing staff at Absolut concerning a possible femur fracture in Patient E;
- failing to document Patient F's allergy to the medication, Cardizem, for nine days during the Patient's stay at Mercy and failing to document the Patient's diagnosis for atrial fibrillation in a discharge summary;
- failing to evaluate Patient G adequately and in a timely manner, resulting in a 4.5 hour delay in admitting the Patient to Mercy;
- refusing to receive a telephone update on Patient H's condition; and,
- failing to order oral antibiotics after the loss of intravenous access for Patient I.

The Committee found that the Respondent's conduct amounted to the failure to follow accepted medical practice, or negligence, rather than a lack of skill or knowledge necessary to practice, which would constitute incompetence. The Committee dismissed all charges alleging incompetence or gross incompetence.

In making their findings, the Committee credited the testimony by the Respondent's expert witness, James Lehayne, M.D. and the Committee indicated that they gave Dr. Lehayne's testimony great weight. The Committee also credited testimony by Thomas Raab, M.D., Sevak Soukiazian, M.D., Maria Prior, R.N., Jacqueline Piotrowski, R.N. and Ms. Linda Szafler. Those persons testified as fact witnesses. The Committee noted that no separate expert witness appeared for the Respondent and that the Respondent did testify on his own behalf. The Committee found that the Respondent possessed a stake in the outcome of the proceeding and

the Committee found that the Respondent's answers often lacked credibility. The Committee also found that the Respondent's selective recall to some questions revealed a strategy to avoid having to respond to certain questions.

The Committee voted to suspend the Respondent's License for three years, to stay the suspension in full and to place the Respondent on probation for three years, under the terms that appear at Attachment A to the Committee's Determination. The probation terms include the requirement that the Respondent practice under supervision. The Committee also voted to limit the Respondent's License to prohibit his practice as a hospitalist, without prior approval from the Director of the Office for Professional Medical Conduct (OPMC Director) to work as part of a multi-person group hospitalist practice with a defined shift structure. The Committee indicated that they chose the penalty to allow the Respondent to remain in practice, but to address the Respondent's repeated failure to exercise the care that a reasonably prudent physician would exercise under the circumstances.

Review History and Issues

The Committee rendered their Determination on February 1, 2012. This proceeding commenced on February 9, 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 reply brief and the Petitioner's brief and reply brief. The record closed when the ARB received the Respondent's reply brief on May 25, 2012.

The Respondent asked the ARB to overturn the Committee's determination because the investigation and prosecution of the charges failed to comply with the timelines set out under PHL § 230. The Respondent argued further that the evidence before the Committee failed to

support any findings of misconduct, beyond minor record keeping errors. Finally, the Respondent argued that the Committee imposed an overly harsh penalty.

In reply to the Respondent, the Petitioner argued that PHL § 230(10)(j) limited the Respondent to raising objections concerning the § 230 time limitations only in a proceeding in the courts. The Petitioner requested that the ARB overturn the Committee and find that the Respondent's conduct in back dating the record for Patient B amounted to fraud and willfully filing a false report and that the Respondent's conduct evidenced moral unfitness in the practice of medicine. The Petitioner also requested that the ARB affirm additional misconduct specifications relating to the treatment for Patient G. In addition, the Petitioner requested that the ARB overturn the penalty that the Committee imposed and that the ARB revoke the Respondent's License. In the alternative, the Petitioner requested that the ARB suspend the Respondent's License for at least one year and that the ARB place the Respondent on probation for three years, with a requirement for practice supervision.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS

2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

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

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion and with gross negligence and failed to maintain accurate patient records. The ARB amends paragraph 1 in the Committee's Order to remove the word "Seventeenth" in the first sentence of

the paragraph and to substitute the word "Eighteenth". The ARB affirms the Committee's Determination to dismiss the remaining charges against the Respondent. We affirm the Committee's Determination to suspend the Respondent's License for three years and to stay the suspension in full. The ARB overturns the Committee's Determination to limit the Respondent's License. The ARB affirms the Committee's Determination to place the Respondent on probation for three years under the terms that appear as Attachment A to the Committee's Determination, except that we amend paragraphs 2 and 8 in the probation terms.

At the outset, the Respondent asked the ARB to find that the Committee lacked the jurisdiction to conduct a hearing in this matter because the Petitioner failed to comply with the time restrictions for investigations and prosecutions against physicians that appear at PHL § 230. The Petitioner replied that PHL § 230(10)(j) provides that any challenge pursuant to the § 230 timelines may come only in a court proceeding under Article 78 of the New York Civil Practice Law and Rules (McKinney Supp. 2012). The ARB agrees with the Petitioner that the PHL §230(10)(j) precludes the ARB from reviewing challenges under the timelines and we leave the Respondent to raise those issues in the courts.

The ARB finds that the evidence before the Committee demonstrated that the Respondent practiced with gross negligence in treating Patient A and with negligence on more than one occasion in treating each Patients A-I. The ARB also finds that the Respondent failed to maintain accurate records for Patients A, B, C, F and I. The expert testimony by Dr. Leyhane and the fact testimony by witnesses Raab, Soukiazian, Prior, Piotrowski and Szafler established a pattern of carelessness, unresponsiveness, undue haste and failure to follow accepted care standards. The Committee found that contrary testimony by the Respondent lacked credibility. The ARB defers to the Committee, as the fact finder, in their judgment on credibility. The evidence that the

Committee found credible proved by a preponderance of the evidence that the Respondent practiced with negligence on more than one occasion in treating all patients, with gross negligence in treating Patient A and that the Respondent failed to maintain accurate records for Patients A, B, C, F and I.

The Committee also found that carelessness or haste accounted for errors in patient care rather than a lack of skill or knowledge necessary to practice medicine safely, so the Committee dismissed charges that the Respondent practiced with gross incompetence and incompetence on more than one occasion. The Committee found further that the Respondent backdated the records for Patient B due to careless practice, rather than from willfulness or the intent to deceive. The Committee dismissed charges that, in backdating the record, the Respondent practiced with fraud, made a false report and engaged in conduct that evidenced moral unfitness. Again, the ARB defers to the Committee in their judgment and we reject the Petitioner's request that we overturn the Committee and sustain the incompetence, fraud, moral unfitness and false report charges. We also reject the Petitioner's request that we affirm additional charges pertaining to the care for Patient G.

The ARB agrees with the Petitioner that the Committee's Order contains an obvious drafting error. The Petitioner's Statement of Charges at the Seventeenth Specification [Committee Determination Appendix I] charged the Respondent with practicing with incompetence on more than one occasion. The Charges at the Eighteenth Specification charged that the Respondent practiced with negligence on more than one occasion. The Committee made clear in their Determination that they sustained the negligence charge and dismissed the incompetence charge and at pages 51-52 in the Determination, the Committee stated specifically that they sustained Specification Eighteenth and dismissed Specification Seventeenth. The

Committee's Order, at Paragraph 1, supposedly listed the Specifications the Committee sustained. Paragraph 1 stated incorrectly that the Committee sustained Specification Seventeenth, but made no mention of Specification Eighteenth. That error in Paragraph 1 is inconsistent with the Committee's Findings and Conclusions and the ARB amends Paragraph 1 to substitute the word "Eighteenth" for the word "Seventeenth".

The ARB affirms the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for three years. We agree that the Respondent should practice under supervision during probation. The supervision would address the Respondent's carelessness and unresponsiveness and it would determine whether the Respondent has made any improvement in his practice. We overturn the Committee's Determination to limit the Respondent's License to prevent the Respondent to practice as a hospitalist. The ARB finds that limitation inconsistent with the Committee's requirement that the Respondent practice under supervision during probation. The ARB finds that a hospital setting, subject to State inspection and with established lines of supervision, would provide the best environment for the Respondent's practice during probation. The Committee's conclusions spoke of probation with an "onsite physician" supervising the Respondent and paragraph 5 in the Committee's Order required direct actual supervision. The Petitioner's brief points out that the Probation Terms on supervision, at paragraph 5, make no mention about actual or onsite probation. We accept the Petitioner's request that we amend the Probation Terms. The ARB amends the second sentence in Probation Term paragraph 5 to read:

"The supervising physician must be onsite at the Respondent's practice location, in a position to regularly observe and assess the Respondent's medical practice, and with direct actual supervision over the Respondent."

The OPMC Director must approve the supervising physician. We amend Probation Term paragraph 2 to update the address for OPMC to Riverview Center, 150 Broadway, Menands, NY 12204.

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 suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for three years, but we amend Paragraphs 2 and 5 in the Probation Terms.
3. The ARB overturns the Committee's Determination to limit the Respondent's License.

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

In the Matter of Tariq Niaz Ahmad, M.D.

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

Dated: 7 September, 2012

Redacted Signature

Linda Prescott Wilson

Peter S. Koenig, Sr., an ARB Member concurs in the Determination and Order in the Matter of Dr. Ahmad.

Dated: ____September 5, 2012

Redacted Signature

Peter S. Koenig, Sr.

In the Matter of Tariq Niaz Ahmad, M.D.

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

Dated: 9/13, 2012

REDACTED SIGNATURE

Datta G. Wagle, M.D.

In the Matter of Tariq Niaz Ahmad, M.D.

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

Date: September 5, 2012

REDACTED SIGNATURE

Richard D. Milone, M.D.

In the Matter of Tariq Niaz Ahmad, M.D.

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

Dated: 9-12, 2012

REDACTED SIGNATURE

John A. D'Anna, M.D.