NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

Public

September 16, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christine M. Radman, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Georges Ramalanjaona, M.D.
REDACTED

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates, PC
1123 Broadway – Suite 1117
New York, New York 10010

RE: In the Matter of Georges Ramalanjaona, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-228) 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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

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

Georges Ramalanjaona, 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. 14-228

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

For the Department of Health (Petitioner): Christine M. Radman, Esq.
For the Respondent: Nathan L. Dembin, Esq.

Following a hearing below, a BPMC Committee determined that the Respondent committed professional misconduct in treating six patients. The Committee voted to suspend the Respondent's license to practice medicine in New York State (License) until the Respondent completes an approved course in record keeping and to place the Respondent on probation for two years following the suspension, under terms that include a practice monitor who will review the Respondent's medical charts. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2014), the Petitioner asks the ARB to overturn the Determination on penalty and to revoke the Respondent's License. After reviewing the record below and the parties' review submissions, the ARB affirms 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(2-6) & 6530(32) (McKinney Supp. 2014) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently;
- practicing medicine with negligence on more than one occasion;
- practicing medicine with gross negligence;
- practicing medicine with incompetence on more than one occasion;
- practicing medicine with gross incompetence; and,
- failing to maintain adequate patient records.

The charges related to the care that the Respondent provided to six persons (Patients A-F) at the Emergency Department at North Shore Long Island Jewish Health System at Plainview Hospital (North Shore) in April and July 2009 and to the information that the Respondent provided on the 1991 application for his License to the New York State Education Department. The record refers to the Patients by initials to protect patient privacy. Following the hearing, the Committee rendered the Determination now under review.

The Committee sustained the charges that the Respondent practiced with negligence on more than one occasion in treating Patients A-F, with gross negligence in treating Patient B and that the Respondent failed to maintain records that accurately reflected evaluation and treatment for Patients A, B, D, E and F. On the negligence charges, the Committee found that the Respondent failed to:

- obtain adequate patient histories for Patients A, B, C, D and F;
- perform adequate physical examinations for Patients A, C, D and E;
- treat Patient A appropriately for a heart attack;
- assess and address chest heaviness in Patient B, despite coronary risk factors;
- document and address CT scan results for Patient B that revealed urinary tract blockage due to obstructing kidney stones;

- provide appropriate amounts of IV fluids and IV antibiotics to treat sepsis in Patient B;
- document medications that Patient B took;
- examine Patient C's heart despite a history for congestive heart failure and atrial fibrillation;
- re-evaluate Patient E after obtaining abnormal cardiac blood test results; and,
- treat Patient F adequately by ordering a brain scan.

The Committee also found that the Respondent diagnosed Patient D incorrectly as suffering upper respiratory failure.

The Committee dismissed the charges that the Respondent practiced with incompetence on more than one occasion and with gross incompetence. The Committee concluded that the Respondent's deficiencies and misdiagnosis resulted from a failure to practice by accepted standards, the definition for negligence, rather than from a lack of the necessary skill or knowledge to practice medicine safely, the definition for incompetence. The Committee also found that the Respondent answered falsely on the application for his License from the New York State Education Department. The Committee found further that the Respondent intended to deceive by that false answer. The Committee found that the false answer did not amount to fraud in practice as defined in EL § 6580(2). The Committee determined that the Respondent's conduct did not occur in practice, but instead might have amounted to obtaining a license fraudulently, a violation under EL § 6580(1). The Petitioner charged fraud in practice rather than fraud in obtaining the License. The Committee dismissed the charge that the Respondent practiced fraudulently.

In making their findings, the Committee found that the Petitioner's expert witness, Joseph Graber, M.D., and the Respondent's expert witness, Timothy Haydock, M.D., both possessed requisite experience and credentials and both were credible. The Committee stated that Dr. Haydock lost some credibility in situations in which he would have to disagree with the care the Respondent offered, but Dr. Haydock found a way to support the Respondent. The Committee noted that Dr. Haydock agreed with the medical axiom that if something wasn't written in the

medical chart, it wasn't done, but Dr. Haydock consistently testified that the Respondent did it, even if he didn't write it. The Committee stated that in instances in which the experts disagreed on an allegation, but the Committee found the experts' testimony equal in weight, the Committee ruled that the Petitioner failed to prove the allegation, because the Petitioner bore the burden to prove the allegation by a preponderance of the evidence. The Committee found the Respondent's testimony obfuscating, tangential, non-forthcoming and self-congratulatory at times. The Committee also found, however, that the Respondent possessed the requisite knowledge, training and experience so that the Committee credited much of the Respondent's testimony and gave the testimony weight accordingly with other testimony and support or lack thereof in the record. The Committee did reject the Respondent's repeated explanation that he always performed cardiac exams on his patients, even if he failed consistently to document the exams. The Committee credited the testimony by Dr. Graber that if an exam is undocumented, it supports the conclusion that the exam wasn't performed. The Committee noted that although the Respondent's counsel argued that the Petitioner failed to meet its burden to prove the charges, the Respondent and Dr. Haydock conceded that the Respondent's record keeping was somewhat lacking.

The Committee voted to suspend the Respondent's License wholly until such time as the Respondent demonstrates to the Director of the Office for Professional Medical Conduct (OPMC) that the Respondent has completed satisfactorily a course in record keeping, which the OPMC Director would have approved previously. Following satisfactory completion of the records course, the Respondent will be on probation for two years. The probation terms appear at Appendix 2 to the Committee's Determination. The probation terms include a practice monitor who will review the Respondent's medical charts and report quarterly to OPMC.

Review History and Issues

The Committee rendered their Determination on June 3, 2014. This proceeding commenced on June 9, 2014, when the ARB received the Petitioner's Notice requesting a Review. The Respondent also requested 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 reply briefs on July 31, 2014.

The Respondent's Brief argues that in evaluating this case one must consider the role of the emergency room physician and the qualifications of the Respondent's expert witness. The Respondent faults the Committee because it lacked a member who practiced emergency medicine. The Respondent also faults the panel because one member practices at North Shore, the same hospital at which the Respondent practiced. The Respondent questions why a more independent expert, not associated with North Shore, could not have been chosen, if just for appearance sake. At page 11, under the heading "Patient G", the Respondent's brief states: "This shows the prejudgment and bias of OPMC – without basis."

In reply, the Petitioner states that the ARB reviews whether a Determination and Penalty are consistent with the Committee findings of fact and conclusions and whether the Penalty is appropriate and within the scope of penalties under PHL § 230-a. The Petitioner contends that the Respondent's brief fails to address either basis for review. As to the reference in the Respondent's brief to Patient G, the Petitioner points out that there is no Patient G in this case.

The Petitioner argues that the Committee imposed a grossly incommensurate and inadequate penalty. The Petitioner contends that the Respondent's negligence occurred in a setting in which the Respondent was the initial physician, the Respondent failed to diagnose and treat the Patients appropriately and then the Respondent compounded his failures by transferring the Patients to oncoming physicians with insufficient or inconsistent documentation in the Patients' charts. The Petitioner's Brief calls it impossible to see how a practice monitor can protect a patient effectively by reviewing charts after the fact. The Petitioner also faults the

Committee for failing to factor into the penalty the finding that the Respondent provided false information on his licensure application. The Brief concluded that it was inconsistent that serious misconduct can be addressed by a mere two year probationary period. The Petitioner asked that the ARB overturn the Committee and revoke the Respondent's License.

In reply, the Respondent's counsel argues that the Respondent has practiced emergency medicine for over thirty years, without any other disciplinary action, and the allegations in this case address the care that the Respondent provided over a four month period, five years ago.

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 on the charges and on Penalty.

The Respondent's Brief questioned one Committee Member's independence, because the Member practices at North Shore, but the Brief made no specific allegation concerning how the Member's practice at North Shore affected the Member's judgment in the case or the outcome of the case. To disqualify a BPMC member for bias, a party must prove actual bias and show that such bias alone affected the final decision in the case, Wolf v. Ambach, 95 A.D.2d 877, 464 N.Y.S.2d 244 (3rd Dept. 1983). The Respondent made no such showing. The Brief also faulted the Committee because no Committee Member practices emergency medicine. The ARB finds no grounds to overturn the Committee's findings due to the Committee's composition. No statute

or regulation requires that a Committee Member must practice in the same specialty as the Respondent, Gant v. Novello, 302 A.D.2d 690, 754 N.Y.S.2d 746, lv. to appeal den. 100 N.Y.2d 502.

The Respondent's Brief also argued that evaluating this case required one to consider the role of the emergency room physician and the qualifications of the Respondent's expert witness. The Committee in this case did both. Both the Respondent's and Petitioner's experts know emergency medicine and the Committee made specific findings concerning emergency medicine practice [Findings of Fact 1-7, 15]. The Committee also considered the testimony by the Respondent's expert, Dr. Haydock, and assessed that testimony alongside the testimony from the Petitioner's expert, Dr. Garber. The Committee concluded that both experts possessed requisite experience and credentials and both were credible. The Committee found, however, that Dr. Haydock lost some credibility in situations in which he would have to disagree with the care the Respondent offered, but found a way to support the Respondent. The Committee also noted that Dr. Haydock agreed with the medical axiom that if something wasn't written in the medical chart, it wasn't done, but Dr. Haydock consistently testified that the Respondent did it, even if he didn't write it.

The ARB defers to the Committee in their judgments on credibility and the ARB concludes that the evidence that the Committee found credible proved that the Respondent practiced with gross negligence in treating Patient B and with negligence on more than one occasion in treating Patients A-F. We also sustain the findings that the Respondent failed to maintain accurate records. The Respondent and Dr. Haydock conceded that the Respondent's record keeping was somewhat lacking.

The ARB rejects the Petitioner's contention that the Committee imposed an inadequate penalty. We agree with the Committee that the Respondent's misconduct does not rise to the level to warrant revoking the Respondent's License. We find incorrect the Petitioner's argument that the penalty amounts to a mere two year probationary period. The Committee imposed an actual suspension on the Respondent, until such time as the Respondent completes a pre-approved course on record keeping. The actual time away from practice will show the Respondent the consequences that will follow any further misconduct. The suspension will follow the Respondent for the rest of his career and may cause problems for the Respondent with insurers, licensing or credentialing boards and medical facilities. The record in this case shows an egregious problem with the Respondent's record keeping, so the ARB agrees with the Committee's Order that the Respondent obtain training in record keeping. The practice monitor will assess whether the Respondent has corrected his deficiencies and will report quarterly to OPMC on the Respondent's progress or the Respondent's continuing deficiencies. We conclude that the Committee has crafted an appropriate penalty.

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 until such time as the Respondent completes successfully a course on record keeping and to place the Respondent on probation for two years, under the terms at Appendix 2 in the Committee's Determination.

Peter S. Koenig, Sr.
Steven Grabiec, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Georges Ramalanjaona, M.D.

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

Dated: 15 September, 2014

REDACTED

Linda Prescott Wilson

In the Matter of Georges Ramalanjaona, M.D.

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

Dated: September 9, 2014

REDACTED

Peter S. Koenig, Sr.

In the Matter of Georges Ramalanjaona, M.D.

Steven Grabiec, M.D., an ARB Member, concurs in the Determination and Order in the Matter of Dr. Ramalanjaona.

Dated: 9/8/, 2014

REDACTED

Steven Grabiec, M.D.

In the Matter of Georges Ramalanjaona, M.D.

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

Dated: September 8, 2014

REDACTED

Richard D. Milone, M.D.

In the Matter of Georges Ramalanjaona, M.D.

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

Dated: Oct 9, 2014

REDACTED

John A. D'Anna, M.D.