Department of Health

Public

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 23, 2015

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nathanial White, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Michael S. Kelton, Esq.
Jordan S. Fensterman, Esq.
Abrams, Fensterman, Fensterman,
Eisman, Formato, Ferrara & Wolf, LLP
630 Third Avenue – 5th Floor
New York, New York 10017

RE: In the Matter of Mahmoud Hamza, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 15-100) 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER OF MAHMOUD HAMZA, M.D.	DETERMINATION AND ORDER

BPMC#15-100

A Notice of Hearing and Statement of Charges, both dated September 17, 2014, were served upon **MAHMOUD HAMZA, M.D.** ("Respondent"). **WILLIAM TEDESCO, M.D.**, Chairperson, **LYON M. GREENBERG, M.D.**, and **WILLIAM WALENCE, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("Public Health Law"). **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct ("Petitioner" or "Department") appeared by JAMES E. DERING, General Counsel, by **JOEL ABELOVE, ESQ.**, and **NATHANIAL WHITE, ESQ.**, of Counsel. The Respondent was represented by Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP, by **MICHAEL S. KELTON, ESQ.**, and **JORDAN S. FENSTERMAN, ESQ**. Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Pre-Hearing Conference:	October 9, 2014
Hearing Dates:	October 20, 2014 December 8, 2014 December 12, 2014
Witnesses for the Petitioner:	Patient B's Wife Anna Melynne Youngblood, M.D. Patricia Bradley, R.N. Staci Michelson, R.N. Daniel Wiener, M.D.
Witnesses for the Respondent:	Jennifer Smith, N.P. Matt Halloran, R.N. Rami Love, R.N. Mahmoud Hamza, M.D.
Written Submissions Received:	February 20, 2015
Deliberations Held:	March 9, 2015

STATEMENT OF CASE

The Respondent was charged with twenty-one specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York ("Education Law"). On October 20, 2014, the Department amended Factual Allegations B and D. On December 8, 2014, the Department amended the Eighteenth Specification. On January 27, 2015, the Department withdrew Factual Allegations B.2, C.3, D.4 and E.3; amended the Sixth Specification to include Factual Allegations A and A.2 and A and A.3; amended the Sixth Specification to include Factual Allegations C and C.2; amended the Ninth Specification to

include Factual Allegations D and D.3; amended the wording of Factual Allegation C.1; and withdrew the Twenty-first Specification. A copy of the Statement of Charges, as amended, is attached to this Determination and Order as Appendix I.

The Department's expert witness was Dan Weiner, M.D., whose education, training and experience established a sound basis for the information he provided regarding the medical issues involved in this proceeding. However, when Dr. Weiner was confronted with the fact that some of his initial conclusions based on statements in the patient medical records were not confirmed by other statements in the chart, he saw no reason to temper his position. As such, the Hearing Committee gave little weight to Dr. Weiner's application of his medical knowledge to the facts as established in this proceeding by the patient medical records and the testimony of the witnesses.

The Respondent did not provide the testimony of an expert witness in his defense, and the Department contended that the Respondent's own testimony should be given little weight because he at times recalled very specific details of patient encounters almost three years ago yet he could not remember statements allegedly made to the Department's investigator 18 months ago. The Hearing Committee determined, however, that even if the Respondent's recall of his patients may have been exaggerated, the stated facts in the written patient medical records seriously undermined the charges issued by the Department against the

Respondent. Moreover, the Respondent presented himself as sincere, remorseful for his record-keeping deficiencies, and willing to accept any recommendations that the Hearing Committee might have if any deficiencies in his medical practice were found to exist.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and the Respondent, the Hearing Committee hereby makes the following findings of fact:

1. The Respondent was authorized to practice medicine in New York State on or about September 26, 2005 by issuance of license number 237858 (Department Ex. 3; Respondent A).

2. The Respondent was employed for six to eight months as a locum tenens Emergency Room physician at Samaritan Medical Center ("SMC") in Watertown, New York from approximately December 2011 until June 2012.

He worked four nights per week at SMC and usually worked two additional nights at Carthage Hospital which was approximately 20 miles away (T. 331-332).

Patient A Facts

3. Patient A arrived at the SMC Emergency Room on December 31, 2011 at approximately 8:12 p.m. The initial nursing notes indicate that Patient A was a 53-year-old Physician Assistant who had had a recent surgery in Syracuse and a catheter placed that day. Patient A complained of pain in the shaft of his penis which was 10 out of 10 on a pain scale, and he was concerned that the catheter had not been placed properly (Ex. 4, p. 4).

4. The Respondent examined Patient A and found Patient A's abdomen to be non-tender with no organomegaly. The Respondent observed urine in Patient A's Foley catheter and determined that it was functioning (Ex. 4, p.6; T. 357-367).

5. The Respondent did not document the amount or interval of urine output (T. 373-374).

6. The Respondent ordered two five milligram tablets of Percocet to relieve Patient A's pain, and a nurse administered that medication to Patient A (Ex. 4, p. 7; T. 366-367).

7. The Respondent spoke to a SMC urologist who said there was no urologist on call for the SMC Emergency Department that night, but that

the patient could be admitted to the hospitalist and seen by a urologist in the morning (T. 361-363, 367).

8. The Respondent offered Patient A the option of being admitted to the hospital at SMC to be seen by a urologist in the morning and the option of being transferred to a Syracuse hospital where he could be seen by his surgeon (T. 363-364).

9. Patient A chose neither option offered by the Respondent. Instead, he decided to leave SMC and travel to Syracuse the next day to see his urologist. The Respondent did not document this discussion with Patient A (T. 378).

10. Patient A was medically stable and was discharged to his home that night. A nurse explained the discharge instructions which included follow up, referral and medication usage. The nurse recorded that Patient A understood and was receptive to the discharge instructions (Ex. 4, p. 9).

Patient A Discussion

The Department charged the Respondent with failing to identify the etiology of a Foley catheter malfunction, and the Department's expert testified that his opinion was based in part on his belief that Respondent's record contained no comment on whether the Foley catheter was putting out urine. During cross examination, however, the defense established that the diagram of the Foley catheter in the medical record indicates that there was urine in the Foley bag. The unwillingness of

the Department's expert to temper his opinion when he was made aware of this charted medical information caused the Hearing Committee to give his opinion less weight, and the Respondent credibly testified that he examined Patient A and found that the catheter was functioning. The Department did not offer the testimony of Patient A or a copy the medical record from a subsequent treating hospital or physician's office to counter the Respondent's testimony. As such, a preponderance of the evidence did not establish that Patient A's Foley catheter was malfunctioning so that factual allegation was not sustained.

The Department also contended that the Respondent failed to order and/or obtain consultative services and failed to provide a safe discharge plan, but the Hearing Committee was persuaded that Patient A chose to leave the hospital because the catheter was functioning and the medication provided relieved his pain. The nurse's notes in the medical record indicate that Patient A was a Physician Assistant who came to the Emergency Department because of severe pain in the shaft of his penis with no output since the Foley was placed that day. While at SMC, the medical record indicates that urine was observed in the Foley bag, that Patient A was provided medication to alleviate his pain and that he intended to go to the Emergency Department at Upstate Medical Center in Syracuse for follow up with his urologist. Respondent testified that no urologist was available at SMC for the Emergency Department on that night and that Patient A voluntarily left SMC when

given the option of being admitted to SMC or transferred to Upstate Medical Center. In particular when considering the undisputed fact that Patient A was himself a medical professional, the Hearing Committee did not sustain these allegations.

The Hearing Committee did find that the Respondent failed to adequately chart his treatment of Patient A. The chart was inaccurate because Respondent failed to document the amount and interval of the urine output while Patient A was at SMC as well as the conversation in which Patient A decided to leave SMC and obtain treatment at Upstate Medical Center.

Patient B Facts

11. Prior to the Respondent's involvement in his care, Patient B was treated for a pneumothorax at SMC on June 4, 2012 and discharged on June 7, 2012 (Ex 5, p. 10).

12. On June 8, 2012, Patient B was brought to the SMC Emergency Room by ambulance at approximately 7:49 a.m. His presenting complaint was sudden onset of severe shortness of breath and pain (Ex. 5, pp. 20, 39).

13. The Respondent determined that Patient B had developed another pneumothorax. Respondent discussed the need to insert a chest tube with SMC pulmonologist, Anna Melynne Youngblood, M.D., who was at her home and indicated that she could arrive at SMC within 20 to 30 minutes (Ex. 5, p. 13; T. 46).

14. The situation was urgent. Patient B was in severe pain, and his blood oxygen level was down. Therefore, the Respondent decided to promptly attempt insertion of a chest tube to Patient B's thoracic cavity rather than wait for Dr. Youngblood's arrival (T. 222).

15. The chest tube kits at SMC come with vials of lidocaine in them (T. 49, 408).

16. The Respondent administered 5 cc's of Lidocaine to Patient B as a local anesthetic (T. 408).

17. If a physician feels that the patient's blood pressure and breathing can tolerate morphine, administration of morphine to alleviate the patient's pain is appropriate. However, a side effect of morphine is slowing the patient's breathing rate (T. 223).

18. The Respondent did not administer morphine to Patient B because there was a risk that the patient could go into cardiac arrest (T. 412).

19. Placing the chest tube at the correct depth can be difficult, and a physician may be unsuccessful in an initial attempt to place the tube into the air cavity which the physician is attempting to access (T. 221).

20. The Respondent inserted the chest tube, but an x-ray revealed that the chest tube was outside the thoracic cavity (T. 47).

21. The Respondent was about to make a second attempt to insert a chest tube when Dr. Youngblood arrived (T. 420).

22. Dr. Youngblood ordered the administration of 4 milligrams of IV morphine and asked the Respondent if he would like her to take over. The Respondent indicated that he would, and Dr. Youngblood became Patient B's attending physician (T. 48, 75).

Patient B Discussion

The Department alleged that the Respondent failed to administer a local and/or systemic analgesia prior to placing a chest tube to treat Patient B's pneumothorax. The Respondent admitted that he did not administer a systemic analgesia before placing the chest tube but testified that he did administer Lidocaine, a local anesthetic. The Respondent explained that he did not administer Morphine because he was concerned about the patient's blood pressure and oxygen saturation levels, and Morphine has a side effect of slowing a patient's breathing rate.

The Department claimed that the Respondent's testimony about administering Lidocaine was false and offered the testimony of three witnesses. However, Patient B's wife and Dr. Youngblood had no direct knowledge regarding whether the Respondent had administered Lidocaine prior to the chest tube placement because neither was present at that time. And Ms. Bradley's testimony before the Hearing Committee was not credible. She had told the Department's investigator two years earlier that she could not recall whether the Respondent had administered Lidocaine, but she testified at the hearing to a clear recollection

that he did not. She had told the Department's investigator two years earlier that the Respondent used a huge needle on the Respondent, but claimed in her testimony that she was referring to the chest tube when she spoke of his using a huge needle. She testified at the hearing that she never left Patient B's side, but the medical record indicates that another nurse initially provided care to Patient B. Further, the medication record system indicates that Ms. Bradley left Patient B to obtain medications. Finally, Ms. Bradley claimed that the chest tube trays at SMC never come with Lidocaine, but Dr. Youngblood as well as the Respondent testified that they do. In sum, the testimony of the Department's own witnesses and the timing of their entries in the medical record were so inconsistent that the record in this proceeding does not form a reliable basis to sustain this factual allegation against the Respondent by a preponderance of the evidence.

Patient C Facts

23. On December 17, 2011, the State of New York Department of Correctional Services ("NYSDOCS") transported Patient C to the Emergency Room at SMC for a consultation because Patient C had complained of nausea with emesis and abdominal pain for 24 hours with no diarrhea (Ex. 6, pp. 15-17).

24. Patient C arrived at the SMC Emergency Department at 10:44 p.m. The nurse's notes indicate that Patient C's presenting complaint was nausea, vomiting, abdominal pain and diarrhea for two days. The

nurse's notes also indicate that Patient C was comfortable and in no apparent distress (Ex. 6, p. 10).

25. The Respondent obtained an EKG for Patient C and determined that there was no cardiac concern (Ex. 6, p. 7; T. 445).

26. At 11:06 p.m., the Respondent ordered the administration of Zofran with a "GI Cocktail" which was a combination of Donnatal, Maalox and Lidocaine, and the Respondent ordered Patient C's discharge (Ex. 6, pp. 7, 11; T. 242).

27. The Respondent continued to intermittently observe Patient C who remained within the Emergency Department after the medication administration. Patient C was relaxed and in no distress (T. 449-457).

28. A nurse's note at 11:16 p.m. indicates that Patient C was comfortable and in no apparent distress (Ex. 6, p. 10).

29. Patient C left the SMC Emergency Department at 11:48 p.m., and was transported by NYSDOCS back to the correctional facility (Ex. 6, p. 11).

Patient C Discussion

The Department charged the Respondent with failing to re-examine Patient C prior to discharge and discharging him in an inappropriate amount of time. The Department's expert witness acknowledged that the Respondent obtained a quality history, that administering the GI Cocktail to alleviate these symptoms in a patient was appropriate, and that a period of 45 minutes observation is appropriate in some

circumstances (T. 258). The Respondent acknowledged that the prison guards do pressure the Emergency Department personnel to determine whether a NYSDOCS patient will be admitted, but that the customary delay in obtaining return transportation provided him with an ample opportunity to intermittently observe Patient C before he left SMC and was sent back to the care of the medical staff at the correctional facility who had referred him to SMC for a consultation. Therefore, the Hearing Committee found that these allegations against the Respondent have not been established by a preponderance of the evidence.

Patient D Facts

30. On March 17, 2012, Patient D, a ten-week-old child, was brought to the SMC Emergency Room by his mother and grandmother. His mother indicated that the child had twitches on the left side of his body and had vomited after receiving formula that day (Ex. 9, p. 6).

31. A nurse noted that Patient D had tremors of his left arm and leg and reported this observation to the Respondent (Ex. 9, p. 10; T. 489).

32. The Respondent observed Patient D but did not see any seizure activity, and he thought the vomiting had been caused by pyloric stenosis. He ordered blood work, a chest x-ray and an ultrasound (T. 486-488).

33. Based on the ultrasound, the Respondent ruled out pyloric stenosis, but the x-ray showed a right upper lobe infiltrate. The

Respondent decided an early pneumonia could have caused a febrile seizure and that Patient D could be discharged after starting him on Rocephin on another antibiotic (T. 488-490).

34. The nursing staff disagreed with the Respondent's decision to discharge the patient, and Philip Chafe, M.D., was asked by the Respondent and the nursing staff for a second opinion about Patient D's possible seizure activity (Ex. 9, p. 7).

35. Obtaining a CT scan of Patient D's brain could cause an increased risk of a future cancer, but failing to obtain a CT scan could prevent the discovery of a subdural hematoma or tumor and immediate life-threatening consequences (T. 281).

36. When Dr. Chafe entered Patient's D's room with the Respondent and the nursing staff, Patient D was having a local clonic seizure of his left arm and leg (Ex. 9, p. 7; T. 492).

37. The Respondent ordered a CT scan which revealed that Patient D had a subdural hematoma (Ex. 9, p. 25; T. 491-493).

Patient D Discussion

The Respondent examined patient D and obtained a complete history from the patient's mother. The examination of the infant did not reveal any apparent signs of physical abuse, and the Respondent initially believed that the patient's symptoms may have been caused by a case of pyloric stenosis. When that diagnosis was not confirmed by an ultrasound, the Respondent then thought that the infant had had a

febrile seizure caused by an early pneumonia, and he prepared to discharge the patient after starting him on antibiotics.

The Department contended that the Respondent failed to recognize that Patient D had a seizure and failed to order a CT scan, but the record establishes that the Respondent recognized that Patient D was having a seizure when he entered the room with Dr. Chafe and that he ordered a CT scan. Before that moment, the Respondent had observed Patient D intermittently for several hours but did not witness any seizure activity. Although the Respondent may have initiated discharge procedures prematurely, the medical record establishes that the Respondent participated in inviting Dr. Chafe to provide a second opinion. The Respondent's involvement with Dr. Chafe in going to evaluate Patient D for a second opinion persuades the Hearing Committee that the allegation that the Respondent tried to discharge the patient without finding the source of the seizure cannot be sustained.

Patient E Facts

38. On May 19, 2011, Patient E, a 20-year-old male, was brought to the SMC Emergency Room back-boarded and collared following an ATV accident (Ex. 11, p.6).

39. The accident caused significant ligament damage to Patient E's left knee which was a likely fracture and/or a dislocation of the knee (Ex. 11, p. 6; T. 284-285).

40. As he was conducting his initial examination, the Respondent noted the left knee deformity. The Respondent then observed that Patient E's leg was turning blue and was concerned the injury was impeding the patient's blood circulation. Therefore, the Respondent put the patient's leg in an anatomical position and placed it in a knee immobilizer (468-471).

Patient E Discussion

The Department charged the Respondent with manipulating Patient E's knee without medical indication and failing to give him pain medication before manipulating it. However, the Department's expert testified that realigning a patient's leg would be appropriate if the patient had a loss of neuro vascular function. In this matter, the nurse who provided care to Patient E acknowledged that Patient E's foot was swollen and that the Respondent had said that he had to work quickly because Patient E's foot was turning blue, a sign a vascular compromise to his foot. Therefore, the Hearing Committee is persuaded that the Respondent had a medical justification for straightening the patient's leg when placing it in a knee immobilizer and that the Respondent's performance of that procedure before administering morphine was a medical judgement that did not violate the standard of care given the urgency of the situation.

CONCLUSIONS OF LAW

As required by § 230(10)(f) of the Public Health Law, the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (See Prince, Richardson on Evidence § 3-206 [R. Farrell 11th ed. 1995]). Having considered the complete record in this matter, the Hearing Committee concludes that the Department has proved none of the charges against the Respondent by a preponderance of the evidence.

Having considered the complete record in the matter, the Hearing Committee concludes that none of the specifications against the Respondent have been established by a preponderance of the evidence. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

The charges in this matter are based on records of the Emergency Department care provided by the Respondent to five patients. The Hearing Committee felt that the testimony of the Department's four fact witnesses did not substantiate any of the allegations against the Respondent. For example, the testimony of Patient B's wife and Ms. Bradley established that Patient B was in significant pain but provided

no credible evidence to establish the Department's allegation that the Respondent failed to administer a local anesthetic. Further, Ms. Bradley's claim that she stayed beside Patient B was inconsistent with the medical record, and her testimony regarding the contents of the chest tube tray was contradicted by the testimony of another of the Department's witnesses, Dr. Youngblood. Moreover, all three SMC medical professionals who testified for the Department had difficulty reconciling their own testimony with the time sequence of the SMC Emergency Department electronic medical records upon which Dr. Weiner, the Department's expert, based his opinion.

The First through Fifth and the Eleventh though Fifteenth Specifications also cannot sustained as a matter of law even if the Department had established those factual allegations. Each of these ten separate specifications charge the Respondent with either negligence or incompetence on more than one occasion. The Court of Appeals has interpreted the phrase "negligence on more than one occasion" to require a finding of "distinct events of some duration during which an act or acts amounting to ordinary negligence occur" (Matter of Yong-Myun Rho v Ambach, 74 NY2d 318, 322 [1989]). Here, the Department has based ten separate specifications on the Respondent's care during a single patient visit to the Emergency Department at SMC. For example, the Third Specification of misconduct is that the Respondent practiced negligence on more than one occasion as alleged in the facts of paragraphs C and

C.1, C and C.2, and/or C and C.3. However, those three allegations relate to the Respondent's examination, documentation and discharge of Patient C on only one occasion during which Patient C was seen for a consultation by the Respondent at SMC's Emergency Department.

The Respondent acknowledged that at times he failed to record sufficient details of the patient complaints, the scope of his physical examinations and findings, and his treatment of these patients. A factual allegation regarding the Respondent having failed to adequately chart his treatment of Patient A was sustained, but the Department withdrew the specification in the Statement of Charges related to accurate record maintenance.

Since the Hearing Committee did not sustain any specification of misconduct in the Statement of Charges as amended, a penalty cannot be imposed. Nonetheless, the Hearing Committee had some concerns regarding the Respondent's practice of medicine. First, the Hearing Committee felt that the Respondent's hurried focus on the presenting medical issues of Patient B and Patient E may have led to an insensitivity toward the pain being experienced by those patients. Although the Respondent's conduct in that regard did not fall below the minimally acceptable standard of care, the Hearing Committee recommends that the Respondent follow through on his offer to take a refresher course in pain management in order to improve the level of care that he provides to his patients. Second, the Respondent by his own admission has failed

to maintain sufficiently accurate medical records of his patient encounters. Therefore, the Hearing Committee strongly recommends that the Respondent take a medical record-keeping course to ensure that his medical records in the future accurately reflect his evaluation and treatment of his patients.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The twenty specifications of professional misconduct set forth in the Statement of Charges as amended are **DISMISSED**;

2. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon the Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
4/17/ , **2015**

WILLIAM TEDESCO, M.D. (CHAIR)

LYON M. GREENBERG, M.D.
WILLIAM WALENCE, Ph.D.

TO: Nathanial White, Esq.
Assistant Counsel
Bureau of Professional Medical Conduct
NYS Department of Health
Corning Tower - Room 2512
Albany, New York 12237

Michael S. Kelton, Esq.
Jordan S. Fensterman, Esq.
Abrams, Fensterman, Fensterman,
Eisman, Formato, Ferrara & Wolf, LLP
630 Third Avenue, 5th Floor
New York, New York 10017

APPENDIX I

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

IN THE MATTER OF MAHMOUD HAMZA, M.D.	STATEMENT OF CHARGES

MAHMOUD HAMZA, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 26, 2005, by the issuance of license number 237858 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided care and treatment to Patient A (Patients are identified in the attached Appendix), a 53-year-old male, on December 31, 2011, at the Emergency Department of Samaritan Medical Center, Watertown, New York. Patient A presented with extreme pain following a Nesbit procedure for Peyronie's disease, on December 30, 2011, and insertion of a Foley catheter upon development of a seroma. Respondent's care and treatment of Patient A failed to meet the standard of care in that:

1. Respondent failed to identify and correct the etiology of the Foley catheter malfunction.
2. Respondent failed to order and/or obtain consultative services.
3. Respondent failed to provide a safe discharge plan for the patient.
4. Respondent failed to adequately chart his treatment of Patient A.

B. Respondent provided care and treatment to Patient B, a 64-year-old male, at the Emergency Department of Samaritan Medical Center, Watertown, New York, on June 8 ~~4~~, 2012. Patient B presented with a right-sided pneumothorax that required chest tube placement. Respondent's care and treatment of Patient B failed to meet the standard of care in that:

1. Respondent failed to administer local and/or systemic analgesia prior to placement of the chest tube.
2. ~~Respondent failed to adequately document why he did not administer local and/or systemic analgesia prior to placement of the chest tube.~~

Withdrawn by Dept on 1/28/15 - WL

C. Respondent provided care and treatment to Patient C, a 45–year-old male, at the Emergency Department of Samaritan Medical Center, Watertown, New York, on December 17, 2011. Patient C presented with abdominal pain and nausea, vomiting, and diarrhea for two days. Respondent's care and treatment of Patient C failed to meet the standard of care in that:

1. Respondent discharged Patient C after an inappropriate amount of time. ~~only 22 minutes after giving the patient a "GI cocktail," which was an inappropriately short period of time.~~ Amended by Dept on 1/28/15 - WL
2. Respondent failed to re-examine Patient C prior to discharge.
3. ~~Respondent failed to adequately document his assessment and treatment of Patient C.~~ Withdrawn by Dept on 1/28/15 - WL

D. Respondent provided care and treatment to Patient D, a 2–month-old male, at the Emergency Department of Samaritan Medical Center, Watertown, New York, on March 17 ~~January 3~~, 2012. Patient D's mother indicated that Patient D had twitches on the left side of his body, and vomited after receiving formula. Respondent's care and treatment of Patient D failed to meet the standard of care in that:

1. Respondent failed to recognize that Patient D had a seizure.
2. Respondent failed to order a CT scan in this afebrile patient who was seizing, despite those indications.
3. Respondent tried to discharge Patient D without finding the source of the seizure.
4. ~~Respondent's failed to adequately chart his assessment and treatment of Patient D.~~ Withdrawn by Dept on 1/20/15 – WL

E. Respondent provided care and treatment to Patient E, a 20–year-old male, at the Emergency Department of Samaritan Medical Center, Watertown, New York, on May 19, 2012. Patient E presented with a ~~left~~ knee dislocation following an ATV accident. Respondent's care and treatment of Patient E failed to meet the standard of care in that:

1. Respondent failed to give Patient E pain medication before manipulation of his left leg.
2. Respondent manipulated Patient E's left leg without medical indication.
3. ~~Respondent failed to document a reason why he manipulated Patient E's left leg.~~ Withdrawn by Dept on 1/20/15 – WL

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. A and A.1, A and A.2, A and A.3, and/or A and A.4.
2. B and B.1, and/or B and B.2.
3. C and C.1, C and C.2, and/or C and C.3.
4. D and D.1, D and D.2, D and D.3, and/or D and D.4.
5. E and E.1, E and E.2, and/or E and E.3.

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

6. A and A.1., A and A.2, and/or A and A.3.

Amended by Dept on 1/28/15

7. B and B.1.

8. C and C.1., C and C.2, Amended by Dept on 1/28/15 - WC

9. D and D.1, and/or D and D.2., D and D.3 Amended by Dept on 1/28/15 - WC

10. E and E.1.

ELEVENTH THROUGH FIFTEENTH SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

11. A and A.1, A and A.2, A and A.3, and/or A and A.4.

12. B and B.1, and/or B and B.2.

13. C and C.1, C and C.2, and/or C and C.3.

14. D and D.1, D and D.2, D and D.3, and/or D and D.4.

15. E and E.1, E and E.2, and/or E and E.3.

SIXTEENTH THROUGH TWENTIETH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence alleged in the facts of the following:

16. A and A.1.

17. B and B.1.

18. C and C.1, and/or C and C.2.

Amended by Dept [illegible]

19. D and D.1, D and D.2, and/or D and D.3.

20. E and E.1, and/or E and E.2.

~~TWENTY-FIRST SPECIFICATION~~

~~RECORD KEEPING~~

withdrawn by Dept on 1/28/15 - WL

~~Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, alleged in the facts of the following:~~

~~21. A and A.3, B and B.2, C and C.3, D and D.4, and/or E and E.3.~~

DATE: September 17, 2014
Albany, New York

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct