THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

August 15, 1990

Mahomed Amirana, Physician
2416 21st Street
Troy, N.Y. 12180

Re: License No. 098036

Dear Dr. Amirana:

Enclosed please find Commissioner's Order No. 10694. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Lawrence F. Sovik, Esq.
300 Empire Building
472 South Salinas Street
Syracuse, N.Y. 13202-2473

REPORT OF THE
REGENTS REVIEW COMMITTEE

MAHOMED AMIRANA

CALENDAR NO. 10694

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

MAHOMED AMIRANA **No. 10694**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

MAHOMED AMIRANA, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on 12 separate dates from October 25, 1988 to July 18, 1989 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the second amended statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of

the first specification of the second amended statement of charges based on negligence on more than one occasion to the extent indicated in its report, the third specification of the second amended statement of charges, the fifth specification of the second amended statement of charges, and the sixth specification of the second amended statement of charges, and not guilty of the remaining charges. Paragraphs D1 and F1 of the second amended statement of charges were withdrawn.

The hearing committee recommended that respondent's license to practice as a physician in the State of New York be revoked, that the revocation be stayed, that respondent be penalized $10,000 for each instance where the surgery was either not indicated or was exaggerated, specifically charges A2, B2, C3, D2, F2 and F3, for a total of $60,000, and that respondent be required to perform 100 hours of public service.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the recommendation of the hearing committee be modified as follows:

> Respondent should be fined in the amount of $60,000 and required to perform 100 hours of public service as calculated by the Committee.
>
> Respondent's license to practice medicine should be revoked and such revocation should be stayed provided respondent complies with the following conditions during the three year period commencing with the effective date of the order of the Commissioner of Education.
>
> 1. Respondent's practice shall be monitored by a board certified surgeon approved in advance by

the Office of Professional Medical Conduct (OPMC).

2. The monitoring surgeon shall submit quarterly reports to OPMC concerning the quality of respondent's practice.

3. Whenever respondent's differential diagnosis of a patient includes malignancy, respondent shall consult with a board certified oncologist.

4. Whenever during the first year after the effective date of the order of the Commissioner of Education respondent is performing surgery, a board certified surgeon or, in the case of pulmonary surgery, a board certified pulmonary surgeon, shall be in attendance.

If respondent satisfies the conditions set forth above during the three year period, the revocation of his license shall be removed.

A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On May 31, 1990 respondent appeared before us in person and was represented by his attorney, Laurence F. Sovik, Esq., who presented oral argument on behalf of respondent. Anna D. Colello, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be revoked, said revocation to be stayed if the following conditions are met:

1. Respondent shall be monitored by a board certified surgeon approved in advance by OPMC.

2. The monitoring surgeon shall submit quarterly reports to OPMC concerning the quality of respondent's practice.

3. Whenever a differential diagnosis of a patient includes malignancy, respondent shall consult with a board certified oncologist.

4. Whenever during the first year after the effective date of the order, respondent is performing surgery a board certified surgeon, or in the case of pulmonary surgery, a board certified pulmonary surgeon shall be in attendance.

If respondent satisfies the conditions set forth above during the three year period the revocation of his license shall be removed. The respondent should also be fined $60,000 and be required to perform 100 hours of public service as calculated by the Committee.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was:

"Respondent practices general and thoracic surgery. Monitoring should be confined only to thoracic surgery which is the subject of these charges. The monetary penalties are excessive especially for charges involving pleurectomies an incidental and minor procedure. Respondent cannot compel referring physicians to bring in oncology consultation. Respondent's recommendations if charges are sustained

1. Practice to be monitored by board certified surgeon approved by OPMC

2. Monitoring surgeon to submit quarterly reports for 2 years

3. During first year after effective date of order of Commissioner of Education respondent shall obtain consultation by board certified pulmonologist, thoracic surgeon or oncologist before proceeding with thoracic surgery for malignant disease

4. No fine or minimum fine for pleurectomies or inaccurate record keeping."

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's March 12, 1990 letter.

In our unanimous opinion, the hearing committee's findings and conclusions are appropriately based on the evidence in the record and the hearing committee properly evaluated respondent's actions under appropriate medical standards. However, we reject the hearing committee's gratuitous statement that it would have found respondent guilty of the charges that were withdrawn.

We differ with the hearing committee and Commissioner of Health as to the appropriate measure of discipline in this case. At the outset, it is noted that the hearing committee recommended a $10,000 fine upon six subparagraphs which are all part of the first specification. Five of these subparagraphs were re-alleged in five subsequent specifications, two of which were not sustained. Under Education Law §6511, a fine, not to exceed $10,000, can only be imposed upon each specification of which respondent was found guilty. Neither the hearing committee nor the Commissioner of Health made any attempt to assess the fine per specification as required by statute. This is unauthorized, and we recommend rejection of the fine. In addition, it is our unanimous opinion that our recommended measure of discipline herein is more appropriate under the circumstances.

Furthermore, we note that the penalty recommended by the Commissioner of Health is unworkable because the conditions under

which the proposed revocation may or may not be stayed relate to various times in the future after the penalty becomes effective. Therefore, it is uncertain whether the revocation is to be stayed immediately, only after respondent arranges for monitoring, only after such monitoring is approved, only after each quarterly report is submitted, or after further determinations are made, piecemeal, that the conditions have been fulfilled. Furthermore, there is no mechanism, as there would have been had there been a complete stay and probation imposed, under which to determine a disputed alleged violation of any condition. In our opinion, the formulation of the penalty recommended by the Commissioner of Health would not sufficiently enable the public, the State, and the parties to know, during the penalty period, whether respondent may practice medicine. The recommendation of the Commissioner of Health should be modified to assure compliance with Education Law §6511 and §6511-a. Our recommendation achieves this goal.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 52 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's statement at page 20 of its report that: "The Hearing Committee notes that the facts

would have been warranted Sustaining the charges specified in Paragraphs D1 and F1 had they not been withdrawn by the Petitioner" not be accepted;

3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the second amended statement of charges based on negligence on more than one occasion to the extent indicated in the hearing committee's report, the third specification of the second amended statement of charges, the fifth specification of the second amended statement of charges, and the sixth specification of the second amended statement of charges, and not guilty of the remaining charges; and

5. That, for the reasons previously stated in this report, respondent's license to practice as a physician in the State of New York be suspended for five years and respondent be required to perform 100 hours of public service in the field of medicine for indigent patients upon each specification of the second amended statement of charges of which we recommend respondent be found guilty, said suspensions to run concurrently and said public service to be imposed concurrently and to total

100 hours, that execution of said suspensions be stayed, and respondent be placed on probation for five years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D", said probation terms to include, among other things, monitoring of respondent's practice in the areas of thoracic and pulmonary surgery, and requiring respondent to obtain the consultation of an oncologist before proceeding with thoracic or pulmonary surgery for any malignant disease.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 7/6/90

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

IN THE MATTER	:	SECOND AMENDED STATEMENT
OF	:	OF
MAHOMED AMIRANA, M.D.	:	CHARGES

MAHOMED AMIRANA, M.D. hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on January 3, 1967 by the issuance of License Number 098036 by the State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from 2416 21st Street, Troy, New York 12180.

Dept EX 1A
ID. EVD.
DATE 6-12-89
JOANNE DE STEFANO

FACTUAL ALLEGATIONS

A. On or about June 28, 1983 Patient A (Patient A as well as all other patients are identified in Appendix A) was admitted to St. Mary's Hospital, Troy, New York (hereafter St. Mary's Hospital) for the complaints of left chest discomfort, increasing shortness of breath, cough and occasional hemoptysis. Patient A was referred to Respondent for a thoracic consult. Respondent while treating Patient A at St. Mary's Hospital:

EXHIBIT "A"

1. performed a pulmonary resection of the left lung without adequate preoperative evaluation of the right lung.

2. performed a pleurectomy which was not indicated and/or prepared a record of the operative procedure dated July 7, 1983 which did not accurately reflect the treatment of Patient A.

B. On or about July 20, 1983, Patient B was admitted to St. Mary's Hospital with a diagnosis of a main mass in the right lung. Patient B was referred to Respondent for a thoracic consult. Respondent:

1. performed a thoracotomy without adequate preoperative evaluation of the left lung.

2. performed a pleurectomy which was not indicated and/or prepared a record of the operative procedure dated August 1, 1983 which did not accurately reflect the treatment of Patient B.

C. On or about November 7, 1983 Patient C was admitted to St. Mary's Hospital on Respondent's service because of a solitary lesion in the right upper lobe. Respondent:

1. performed a thoracotomy without adequate preoperative evaluation.

2. performed a lobectomy without adequate justification.

3. performed a pleurectomy which was not indicated.

D. On or about February 13, 1984, Patient D was admitted to St. Mary's Hospital with a large mass of the left upper lobe. Patient D was referred to Respondent for a thoracic consult. Respondent:

1. performed a pneumonectomy without adequate preoperative evaluation. (withdrawn)

2. performed a pleurectomy which was not indicated and/or prepared a record of the operative procedure dated February 21, 1984 which did not accurately reflect the treatment of Patient D.

E. On or about June 27, 1983, Patient E was admitted to St. Mary's Hospital with a rounded mass in the left lower lung. Patient E was referred to Respondent on July 1, 1983 for a thoracic consult. Respondent:

1. failed to perform adequate preoperative evaluation;
2. performed a thoracotomy which was not indicated; and
3. performed a pneumonectomy which was not indicated.

F. On or about July 17, 1983 Patient F was admitted to St. Mary's Hospital for a persistent mass in the anterior segment of the right upper lobe. Patient F was referred to Respondent for a thoracic consult. Respondent:

1. failed to obtain adequate preoperative evaluation regarding the mass in the right lung;
2. performed a pleurectomy which was not indicated and/or prepared a record of the operative procedure dated July 18, 1983 which did not accurately reflect the treatment of Patient F.
3. performed a mediastinal lymph node dissection which was not indicated and/or prepared a record of the operative procedure dated July 18, 1983 which did not accurately reflect the treatment of Patient F.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE AND/OR

INCOMPETENCE ON MORE THAN

ONE OCCASION

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1985) in that he practiced the profession of medicine with negligence and/or incompetence on more than one occasion, in that petitioner charges that Respondent has committed two or more of the following:

1. The facts in Paragraphs A and A1, A and A2, B and B1, B and B2, C and C1, C and C2, C and C3, D and D1, D and D2, E and E1, E and E2, E and E3, F and F1, F and F2, and/or F and F3.

SECOND THROUGH SIXTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) in that he failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as required by 8 NYCRR 29.2(a)(3) (1987) in that Petitioner charges:

2. The facts in paragraphs A and A.2. insofar as subparagraph A.2. relates to the record of the operative procedure dated July 7, 1983.

3. The facts in paragraphs B and B.2. insofar as subparagraph B.2. relates to the record of the operative procedure dated August 1, 1983.

4. The facts in apragraphs D and D.2. insofar as subparagraph D.2. relates to the record of the operative procedure dated February 21, 1984.

5. The facts in paragraphs F and F.2. insofar as subparagraph F.2. relates to the record of the operative procedure dated July 18, 1983.

6. The facts in paragraphs F and F.3. insofar as subparagraph F.3. relates to the record of the operative procedure dated July 18, 1983.

DATED: Albany, New York
June 8, 1989

Peter D. Van Buren

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

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
MAHOMED AMIRANA, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Stanley Grossman, M.D., Chairman, Michael R. Golding, M.D. and Mr. Robert Briber, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Michael P. McDermott, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	Dated: July 15, 1988
Amended Statement of Charges:	Dated: August 31, 1988
Second Amended Statement of Charges:	Dated: June 8, 1989

Hearing dates:	October 25, 1988 December 2, 1988 December 9, 1988 March 29, 1989 May 2, 1989 May 8, 1989 May 9, 1989 May 15, 1989 May 22, 1989 June 12, 1989 July 12, 1989 July 18, 1989
Deliberation dates:	September 18, 1989 October 16, 1989 October 23, 1989
Substitution of Administrative Officer:	Michael P. McDermott, Esq., served as Administrative Officer on all hearing dates except on May 2, 1989 when Tyrone Butler, Esq., served as Administrative Officer
Place of hearing:	Albany, New York
Final deliberations:	September 18, 1989 October 16, 1989
Department of Health appeared by:	Peter J. Millock, Esq. General Counsel By: Anna Colello, Esq. of Counsel
Respondent appeared by:	Smith, Sovick, Kendrick, Schwarzer & Sugnet, P.C. 300 Empire Building 472 South Salina Street Syracuse, NY 13202 By: Laurence Sovick, Esq., of Counsel
Witnesses for the Petitioner:	William L. Craver, M.D. Richard H. Feins, M.D.
Witnesses for the Respondent:	John Ferraro, M.D. Ruth Beer, M.D. Rajendra Patel, M.D. Daniel Berkenblit, M.D.

John C. Ruckdeschel, M.D.
Edward J. Beattie, M.D.
K. Venkat Reddy, M.D.
Mahomed Amirana, M.D.

STATEMENT OF CHARGES

Essentially the Statement of Charges alleges that the Respondent practiced the profession of medicine with negligence and/or incompetence on more than one occasion; and with failing to maintain accurate records.

The charges against the Respondent are more specifically set forth in the Second Amended Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript pages unless otherwise noted. These citations represent evidence found persuasive by the Hearing Committee while arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All findings were reached by unanimous vote except where noted otherwise.

As to Patient A:

1. Patient A, a 74 year old female, was admitted to St. Mary's Hospital, Troy, New York on June 28, 1983 with

complaints of left chest pain and hemoptysis (coughing up blood) (Petitioner's Ex. 2, pg. 9).

2. Four x-rays had been taken of Patient A's chest in May-June 1980. The first x-ray on May 12, 1980 revealed congestive heart failure with right side infiltrate which underwent resolution and clearing. The final x-ray on June 27, 1980 revealed that the lungs were clear of infiltration and there was no evidence of congestive heart failure (Respondent's Ex. JJ, KK, LL, MM).

3. A CT scan of Patient A's chest was taken on June 21, 1983 prior to her admission. The CT scan, as noted in the admission chart, indicated a mass in both the right and left lungs (Petitioner's Ex. 2, pg. 44; Tr. 43).

4. Respondent saw Patient A in consultation on June 28, 1983 (Petitioner's Ex. 2, pg. 10). His consult note refers to a large mass in Patient A's left chest and a submandibular mass. There is no mention of the right chest (Petitioner's Ex. 2, pg. 47).

5. Respondent performed a bronchoscopy on Patient A on June 29, 1983. The secretions were negative for malignancy (Petitioner's Ex. 2, pgs. 55-56). Further, Respondent did not establish in this procedure whether the Patient's hemoptysis was from her right or left lung (Tr. 1540-41).

6. A sputum cytology test performed on June 30, 1983, showed keratinizing squamous cell carcinoma (Petitioner's Ex. 2,

pg. 33). That test could not distinguish if the cancerous cells were from Patient A's right or left lung (Tr. 828-29).

7. Respondent performed an excision of the submandibular mass and a right scalene node biopsy on Patient A on July 1, 1983. The specimens were negative for malignancy (Petitioner's Ex. 2, pg. 60-61).

8. Bone involvement was found to exist in a post-operative bone scan. The bone scan taken on July 22, 1983 showed "areas of increased uptake due to a combination of trauma and direct invasion by neoplasm (Petitioner's Ex. 2, pg. 43). A second post-operative bone scan was performed on November 1, 1983 (Respondent's Ex. N). That scan showed no new areas of activity suggesting metastatic disease. However, that scan was taken after Patient A had undergone a course of treatment with radiation (Respondent's Ex. E, pg. 7).

9. Respondent failed to record a diagnosis regarding Patient A's right lung. The right lung is not mentioned in his consult note, the Progress Notes or the Discharge Summary (Petitioner's Ex. 2, pgs. 10-11, 16-17, 47; Tr. 65).

10. On July 7, 1983 the Respondent performed a left thoractomy, a left upper lobectomy, a segmental resection of the left lower lobe, a pleurectomy, a left mediastinal node dissection and intercostal nerve block (Petitioner's Ex. 2, pg. 65).

11. A pleurectomy is the procedure in which the surgeon removes the inner lining from the chest wall. It is performed to

treat recurrent pneumothoraxes or already established malignant pleural effusions (Tr. 69).

12. The Respondent indicated in his Operative Report, "Rest of the pleura was removed in order to avoid any malignant pleural effusion" (Petitioner's Ex. 2, pg. 66).

13. The pathology report for the procedure dated July 7, 1983 indicated that the pleura was invaded by tumor (Petitioner's Ex. 2, pg. 67).

As to Patient B:

14. Patient B, a 71 year old male, was admitted to St. Mary's Hospital, Troy, New York on July 19, 1983 with a history of smoking, a harsh cough and a small amount of "blood in the phlegm." He had chronic obstructive pulmonary disease, arteriosclerotic heart disease with a history of congestive heart failure and hypothyroidism (Petitioner's Ex. 3A, pg. 19).

15. Prior to his admission, Patient B had x-rays taken on June 28 and July 8, 1983 and a CT scan on July 15, 1983. The x-rays revealed a nodular density in the right lower lung (Petitioner's Ex. 3A, pgs. 42-45). The CT scan showed evidence of a 2.5 cm nodule in the right lung and smaller nodules in both lungs suggesting metastatic disease. There was also a 1.5 cm mass posterolateral in the left lung and there was an additional 1.5 cm mass in the apex of the left lung (Petitioner's Ex. 3A, pg. 43).

16. Various other diagnostic tests were performed to check for the presence of metastatic disease: liver scan (July 20);

bone scan and I.V.P. (July 21); Barium enema (July 22) and upper G.I. series (July 25, 1983). All were negative except the barium enema which showed the presence of two polyps (Petitioner's Ex. 3A, pg. 19).

17. Needle biopsies were performed on the right lung on July 25 and 27, 1983. They were inconclusive (Petitioner's Ex. 3A, pgs. 20-21, 38-41).

18. The Respondent failed to perform a needle biopsy of the masses in Patient B's left lung (Petitioner's Ex. 3A, pgs. 20-21).

19. The Respondent saw Patient B in consult on July 29, 1983 (Petitioner's Ex. 3A, pg. 60). In both the Progress Notes and the Consult Note, Respondent only addressed the mass in the right lung and made no mention of the masses in the left lung (Petitioner's Ex. 3A, pgs. 19-22).

20. The Respondent performed a right lower lobectomy, mediastinal lymph node dissection, pleurectomy and intercostal nerve block on Patient B on August 1, 1983 without either a preoperative or intraoperative diagnosis (Petitioner's Ex. 3A, pgs. 71-72).

21. The pathology report indicates that the amount of pleura which was removed measured 15cm x 10cm x 5cm (Petitioner's Ex. 3A, pg. 73).

22. The Respondent performed a bronchoscopy on Patient B before he performed the right thoractomy. However, Respondent did not wait for the results of the bronchial washings before

proceeding to thoracotomy (Petitioner's Ex. 3A, pgs. 71-72; Tr. 295).

As to Patient C

23. Patient C, a 67 year old male, was admitted to St. Mary's Hospital on November 7, 1983 under the Respondent's service because of a possible right lung lesion seen in a recent chest x-ray. Patient C had been followed by Memorial Hospital in New York City since approximately 1977 because of surgery for head and neck cancer (Petitioner's Ex. 10, pg. 7).

24. A tomogram performed on Patient C on an outpatient basis at St. Mary's Hospital on October 27, 1983 confirmed the presence of a solitary lesion in the right lung which was either a new primary carcinoma or metastatic secondary to the prior head and neck carcinoma (Petitioner's Ex. 10, pg. 7, Respondent's Exs. S and DD).

25. A CT scan of Patient C's head, neck and chest was performed on November 8, 1983. The impression noted is "nodular infiltrate right upper lobe... This could be residium of previous inflammatory process although in view of recent evolution of this process in the right upper lobe with the previous negative chest one would have to consider primary neoplastic process". It could not be established by CT scan whether Patient C's new lesion was primary or metastatic (Petitioner's Ex. 10, pg. 36).

26. The Respondent performed a laryngoscopy, bronchoscopy and brush biopsies on November 9, 1983. The laryngoscopy showed

no evidence of cancer in the pharynx and mouth; the bronchoscopy showed no tumors in the visualized areas of the airways; the bronchial washings showed no atypical or malignant cells (Petitioner's Ex. 10, pg. 44; Tr. 418-19).

27. The Respondent failed to make a diagnosis with regard to the lesion in the right upper lobe prior to performing a thoracotomy. The CT scan and x-rays show the lesion to be quite far peripheral. The Respondent, in his Operative Report, describes the lesion as being in "the middle of the right upper lobe" (Petitioner's Ex. 10, 11, and 12).

28. The Pathology Report of the specimen of the upper lobe of the right lung states "The pleura is smooth and shiny. In the postero-lateral aspect there is a subpleural tumor which has been partly incised. The tumor measures 2cm in greatest dimension" (Petitioner's Ex. 10, pg. 51).

29. Respondent's Operative Report indicated that he performed a pleurectomy and he described the pleura being dissected out in the body of his report (Petitioner's Ex. 10, pgs. 49-50).

30. Neither the Operative Report nor the Pathology Report indicated that the pleura was involved with tumor. The Pathology Report describes the tumor as being "subpleural" which supports what is found in the CT report that the tumor was peripheral, just under the pleura and close to, but not involved in the pleura (Petitioner's Ex. 10, pg. 49-51).

As to Patient D

31. Patient D, a 64 year old female, was admitted to St. Mary's Hospital on February 13, 1984 because of a chest x-ray finding of a large mass of the left upper lobe (Petitioner's Ex. 13, pg. 5).

32. The Respondent saw Patient D in consultation on February 19, 1984. He noted that he agreed with the admitting physician that "one should go ahead and do the necessary bronchoscopy and delineate the definite diagnosis..." (Petitioner's Ex. 13, pg. 55).

33. The Respondent performed a bronchoscopy on February 16, 1984. The brush biopsies and washings were positive for malignancy (Petitioner's Ex. 13, pg. 67).

34. On February 18, 1984, the Respondent scheduled Patient D for thoractomy. A radical left pneumonectomy, including removal of pleura and mediastinal lymph node dissection, was performed on February 21, 1984 (Petitioner's Ex. 13, pgs. 7 and 71).

35. The Respondent dissected out "the entire pleura of the chest". The Pathology Report of the pleura specimen indicates "Tumor nests are present with lymphoid aggregates in the pleura" (Petitioner's Ex. 13, pgs. 71 and 73).

As to Patient E

36. Patient E, a 63 year old male, was admitted to St. Mary's Hospital on June 27, 1983 because of a rounded mass in his left lower lung. He also complained of pain in his left

shoulder and numbness in the three middle fingers of his left hand. There was no history of cough, shortness of breath, chest pains, dizziness, tiredness, hemoptysis, headache, visual disturbances, abdominal pains, urinary problems or any weakness (Petitioner Ex. 15, pg. 6).

37. Patient E underwent an I.V.P. and bone scan on June 28, 1983 which showed no strong evidence of metastatic disease. A chest x-ray taken on June 29, 1983 confirmed the presence of the mass within the left lower lobe. A barium enema revealed mild diverticular disease of the sigmoid. An upper GI series performed in July 1, 1983 was normal (Petitioner's Ex. 15, pgs. 31-33).

38. The Respondent saw Patient E in consult on June 29, 1983 and scheduled him for a bronchoscopy (Petitioner's Ex. 15, pg. 41).

39. The bronchoscopy performed on June 30, 1983 by the Respondent was positive for malignancy. It showed large anaplastic carcinoma of the left lower lobe (Petitioner's Ex. 15, pg. 46).

40. The Respondent did not order a tomogram or a CT scan of Patient E's left lung. Tomograms and CT scans were available at St. Mary's Hospital at the time (Tr. 904-905, 1536).

41. The Respondent did not perform a mediastinotomy/mediastinoscopy (Petitioner's Ex. 15, Tr. 533).

42. Patient E had an abnormal LDH level of 445 (normal range 90-225) and an abnormal alkaline phosphatase of 141 (normal range 30-125) (Petitioner's Ex. 15, pg. 23).

43. The elevated LDH and alkaline phosphatase levels indicate the potential for liver involvement and dictate a liver scan. The alkaline phosphatase is the single most sensitive test to establish the presence of liver involvement (Petitioner's Ex. 15, pg. 23; Tr. 525, 1684).

44. The Respondent performed a left radical pneumonectomy and mediastinal lymph node dissection on Patient E on July 5, 1983. The Pathology Report indicated mediastinal lymph node involvement in a specimen labelled mediastinal mass. The nodes showed metastic adenocarcinoma (Petitioner's Ex. 15, pgs. 49-51).

45. Patient E died on November 1, 1983 (Petitioner Ex. 16).

As to Patient F

46. Patient F, a 68 year old male, was admitted to St. Mary's Hospital on July 17, 1983 with complaints of cough and hemoptysis and a mass on the right lung (Petitioner's Ex. 19, pg. 5).

47. Respondent performed a bronchoscopy on Patient F on July 16, 1983 the day prior to the Patient's July hospital admission. The lesion was too peripheral to be examined with the flexible bronchoscope and the brush biopsy was negative for malignancy (Petitioner's Ex. 20, pgs. 4-5).

48. Respondent saw Patient F in consult on July 17, 1983. A repeat chest x-ray and tomogram showed the localized lesion

which Respondent noted to be "carcinoma unless proven otherwise." (Petitioner's Ex. 19, pg. 31).

49. On July 18, 1983 Respondent performed a right upper lobectomy, pleurectomy and mediastinal lymph node dissection on Patient F. In the body of Respondent's Operative Report he further described the procedure, mediastinal lymph node dissection, by stating that "all lymph nodes were removed" (Petitioner's Ex. 19, pg. 37).

50. Despite what is written in his Operative Report, Respondent claims to have removed only one node for the purpose of establishing a diagnosis. However the specimen sent to the Pathology Department was received in formalin and, therefore, could not be used for establishing an immediate diagnosis (Petitioner's Ex. 19, pg. 39 and Ex. 19a; Tr. 717, 761, 775).

51. The pleura was removed before a diagnosis had been made of the right upper lobe. The pleura was not involved by tumor. The pleura was sent to the Pathology Department as a separate specimen; it was not adherent to the lobe (Petitioner's Ex. 19, pg. 39 and Ex. 19a; Tr. 563, 574, 778).

52. Respondent received the result of the frozen section diagnosis of lung mass only in the Operating Room. The diagnosis was "mostly pseudotumor". The final Pathological Report diagnosis received a few days after the operation was "nonresolving pneumonia with abscess formation" (Petitioner's Ex. 19, pg. 38, Ex. 19a).

CONCLUSIONS

As to Patient A:

1. The Respondent performed a pulmonary resection of the left lung without adequate preoperative evaluation of the right lung.

The CT scan of Patient A's chest taken on June 21, 1983 revealed masses in the right and left lungs, both of which should have been addressed by the Respondent.

The Respondent never attempted to perform any diagnostic studies to determine the nature of the mass in the right lung field nor did he document that he even knew that the mass was present.

The excision of the right scalene node and the excision of the submandibular mass, both of which tested negative for malignancy, were not sufficient to determine the nature of the mass in the right lung.

The Respondent did not record any diagnosis for the right lung in his consult note, the progress notes or the discharge summary.

2. The Respondent performed a pleurectomy which was not indicated.

A pleurectomy is a procedure in which the surgeon removes the inner lining from the chest wall. It is performed to treat recurrent pneumothoraxes or already established malignant

plueral effusion. A pleurectomy should not be performed for prophylactic reasons. Even though the Respondent agreed with this (Tr. 1523), his operative report states "Rest of the pleura was removed in order to avoid any malignant pleural effusion" (Petitioner's Ex. 2, pg. 66).

3. The record of the operative procedure is vague and there is insufficient evidence in the hearing record for the Hearing Committee to determine whether or not the Respondent's operative record accurately reflects the treatment of Patient A.

As to Patient B

1. The Respondent performed a right thorocotomy without adequate preoperative evaluation of the left lung.

2. The amount of pleura removed by the Respondent, i.e., 15cm x 10cm x 5cm was too extensive. This type of pleurectomy was not indicated for this patient and exposed the patient to the possibility of additional operative complications. Even the testimony of the Respondent's own medical expert witnesses (Dr. Beattie, Tr. 1256 and Dr. Rucicdeschel, Tr. 1000) does not support the type of procedure performed by the Respondent.

3. The Respondent's written Operative Report even when interpreted in the light of the Respondent's own testimony on the matter still does not reflect the findings reported in the Pathology Report and thus the Operative Report does not accurately

reflect the Respondent's treatment of Patient B (Petitioner's Ex. 3A, pgs. 71-73, Tr. 1602-06).

As to Patient C

1. There is insufficient evidence in the record for the Hearing Committee to conclude that the Respondent performed a thoracotomy without adequate evaluation.

2. The Respondent's Operative Report states that "There was a good sized mass, the size of a small plum, in the middle of the right upper lobe" (Petitioner's Ex. 10, pg. 49). If the mass was in the middle of the lobe, a lobectomy would have been justified.

However, the Respondent's reported findings are not confirmed by the Pathology Report which reports "The pleura is smooth and shiny. In the postero-lateral aspect there is a subpleural tumor which has been partly incised. The tumor measures 2 cm in greatest dimension" (Petitioner's Ex. 10, pg. 51).

In addition, the subpleural location of the tumor made it accessable for pre-operative or intra-operative biopsy so that a definitive diagnosis could have been established prior to the performance of a lobectomy.

3. The Respondent performed a pleurectomy which was not indicated because the mass was not adherent to the pleura nor was the pleura clinically involved by tumor.

The Respondent's Operative Note that "A pleurectomy was performed because of the extra pleural dissection" (Petitioner's Ex. 10, pg. 49; Tr. 426) did not make sense to the Hearing Panel.

The Respondent's testimony as to why he performed the pleurectomy was at variance with the Pathology Report. The Respondent stated that there was adhesion of the lung to the chest wall and that this necessitated an extra pleural disection. The Pathology Report states that "The pleura was smooth and shiny" which is indicative that there was no adherence of the lung to the chest wall. Also, the Pathology Report states that the lung and pleura specimens were received separately again indicating that there was no adhesion (Petitioner's Ex. 10, pgs. 49-51; Tr. 1656-58).

As to Patient D

1. The Petitioner withdrew allegation D1, that the Respondent performed a pneumonectomy without adequate pre-operative evaluation (see footnote on pg. 2 of Petitioner's Discussions, Proposed Findings, Conclusions and Recommendations, dated August 31, 1989).

2. The pleurectomy did reveal the presence of tumor nests with lymphoid aggregates in the pleura. However the Hearing Panel concludes that the tumor had extended to and through the pleura therefore extending beyond the bounds of possible surgical cure or palliation.

As to Patient E

1. The Respondent failed to adequately evaluate the patient pre-operatively by not performing a CT scan of the chest. A CT scan and mediastinotomy/mediastinoscopy would have determined the presence of cancer in the right and left chest thus making both a thoracotomy and pneumonectomy contraindicated.

2. The failure to evaluate the cause of the abnormal LDH and alkaline phosphatase as indicative of metastatic spread to the liver is not acceptable medical practice.

The value of LDH and alkaline phosphatase in this setting is well established, representation by Respondent's counsel to the contrary not withstanding (see Posthearing Memorandum submitted on behalf of Respondent, page 38).

3. In this case, the thoracotomy and pneumonectomy performed by the Respondent were not indicated.

As to Patient F:

1. The Petitioner withdrew Allegation F1, that the Respondent failed to obtain adequate preoperative evaluation regarding the mass in the right lung (Tr. 557).

2. The Respondent performed a pleurectomy which was not indicated and prepared a record of the operative procedure, dated July 18, 1983, which did not accurately reflect the treatment of Patient F. In as much as the pleura was not adherent to the mass, there was no indication for a pleurectomy (Petitioner's Ex. 19, pg. 37).

3. The Respondent did not perform a mediastinal lymph node disection but he did prepare a operative report indicating that such a procedure was performed (Petitioner's Ex. 19, pg. 37; Tr. 565, 566).

GENERAL CONCLUSIONS

The evidence in this case revealed a pattern of premature surgery, wherein the Respondent did not consider all the facts involved but selectively used those facts which might support surgery and ignored those facts which tended to militate against it.

The Hearing Committee concludes that the Respondent was guilty of negligence on more than one occasion, that is, on more than one occasion he failed to exercise the care that would have been exercised by a reasonably prudent physician under the circumstances.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously (3-0) as follows:

FIRST SPECIFICATION

Paragraphs	A-A1	Sustained
Paragraphs	A-A2	Sustained
Paragraphs	B-B1	Sustained
Paragraphs	B-B2	Sustained
Paragraphs	C-C1	Not Sustained
Paragraphs	C-C2	Sustained
Paragraphs	C-C3	Sustained
Paragraphs	D-D1	Withdrawn by the Petitioner
Paragraphs	D-D2	Sustained
Paragraphs	E-E1	Sustained
Paragraphs	E-E2	Sustained
Paragraphs	E-E3	Sustained
Paragraphs	F-F1	Withdrawn by the Petitioner
Paragraphs	F-F2	Sustained
Paragraphs	F-F3	Sustained

The Hearing Committee notes that the facts would have been warranted Sustaining the charges specified in Paragraphs D1 and F1 had they not been withdrawn by the Petitioner

---

The Hearing Committee unanimously concludes that the Respondent failed to maintain accurate records.

Second through Sixth Specifications

Paragraphs	A-A2	Not Sustained
Paragraphs	B-B2	Sustained
Paragraphs	D-D2	Not Sustained
Paragraphs	F-F2	Sustained
Paragraphs	F-F3	Sustained

RECOMMENDATIONS

After reviewing the entire record in this matter the Hearing Committee unanimously concluded that the Respondent possesses an adequate fund of knowledge to practice the profession. Under these circumstances retraining and/or monitoring under probation as suggested by the Petitioner would serve no useful purpose.

The Hearing Committee found that the Respondent was selective in the use of some data and disregarded other valid data to justify surgical procedures which were not justified.

The Hearing Committee also found a pattern of surgical procedures that were either not indicated or were of no benefit to the patient.

The Hearing Committee found a pattern by the Respondent of writing operative reports which either did not accurately describe the actual procedure or exaggerated it. The Hearing Committee will not speculate as to the Respondent's motives for this behavior.

It is the judgement of the Hearing Committee that the Respondent is not incompetent, but rather that he was negligent inasmuch as he disregarded his patients' welfare.

Because of the Respondent's disregard of his patients' welfare, the Hearing Committee recommends unanimously (3-0) that the Respondent's license to practice medicine be REVOKED and that the REVOCATION BE STAYED.

Because of the pattern of performing surgical procedures that were either not indicated or were of no benefit to his patients, the Hearing Committee recommends unanimously (3-0) that the Respondent be penalized Ten Thousand Dollars ($10,000) for each instance where the surgery was either not indicated or was exaggerated, specifically Charges A2, B2, C3, D2, F2 and F3, for a total of Sixty Thousand Dollars ($60,000).

In addition, the Hearing Committee recommends unanimously (3-0) that the Respondent be required to perform one hundred (100) hours of public service, the maximum allowed by statute (§6511 Ed Law), to be certified to the Office of Professional Medical Conduct of the New York State Department of Health.

Were it not for the limitation set by statute, the Hearing Committee would have recommended that the Respondent be required to perform one thousand (1000) hours of public service.

DATED: November 20, 1989

Respectfully submitted,

Stanley Grossman, M.D., Chairman

Michael R. Golding, M.D.
Mr. Robert Briber

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

IN THE MATTER :

OF :

MAHOMED AMIRANA, M.D. :

----------X

COMMISSIONER'S

RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on October 25, 1988, December 2, 1988, December 9, 1988, March 29, 1989, May 2, 1989, May 8, 1989, May 9, 1989, May 15, 1989, May 22, 1989, June 12, 1989, July 12, 1989, July 18, 1989. Respondent, Mahomen Amirana, M.D., appeared by Laurence Sovick, Esq. The evidence in support of the charges against the Respondent was presented by Anna Colello, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full:

B. The Recommendation of the Committee should be modified as follows:

Respondent should be fined in the amount of $60,000 and required to perform 100 hours of public service as calculated by the Committee.

Respondent's license to practice medicine should be revoked and such revocation should be stayed provided Respondent complies with the following conditions during the three year period commencing with the effective date of the order of the Commissioner of Education.

1. Respondent's practice shall be monitored by a board certified surgeon approved in advance by the Office of Professional Medical Conduct (OPMC).

2. The monitoring surgeon shall submit quarterly reports to OPMC concerning the quality of Respondent's practice.

3. Whenever Respondent's differential diagnosis of a patient includes malignancy, Respondent shall consult with a board certified oncologist.

4. Whenever during the first year after the effective date of the order of the Commissioner of Education Respondent is performing surgery, a board certified surgeon or, in the case of pulmonary surgery, a board certified pulmonary surgeon, shall be in attendance.

If Respondent satisfies the conditions set forth above during the three year period, the revocation of his license shall be removed.

The pattern of negligent care by Respondent identified by the Committee cannot be allowed to continue. The monitoring conditions for continued practice will help protect Respondent's patients by ensuring that independent qualified surgeons review Respondent's treatment decisions for a significant period of time.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
January 9, 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

MAHOMED AMIRANA

CALENDAR NO. 10694

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of

Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That, during the period of probation, respondent shall have respondent's practice of thoracic and pulmonary surgery monitored, including required consultation, at respondent's expense, as follows:

   a. That said monitoring shall be by a physician who is board certified in surgery, said physician to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent, at respondent's expense, shall call in, for a formal consultation, a physician who is board certified as an oncologist before proceeding with any thoracic or pulmonary surgery for any malignant disease;

   c. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records and hospital charts in regard to respondent's practice of thoracic and pulmonary surgery, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   d. That said monitor shall submit a report, once every four months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct;

3. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

MAHOMED AMIRANA

CALENDAR NO. 10694

The University of the State of New York

IN THE MATTER

OF

MAHOMED AMIRANA
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10694

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10694, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (July 27, 1990): That, in the matter of MAHOMED AMIRANA, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 52 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's statement at page 20 of its report that: "The Hearing Committee notes that the facts would have been warranted Sustaining the charges specified in Paragraphs D1 and F1 had they not been withdrawn by the Petitioner" not be accepted;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
4. Respondent is guilty, by a preponderance of the evidence, of the first specification of the second amended statement of charges based on negligence on more than one

occasion to the extent indicated in the hearing committee's report, the third specification of the second amended statement of charges, the fifth specification of the second amended statement of charges, and the sixth specification of the second amended statement of charges, and not guilty of the remaining charges; and

5. That, for the reasons previously stated in the report of the Regents Review Committee, respondent's license to practice as a physician in the State of New York be suspended for five years and respondent be required to perform 100 hours of public service in the field of medicine for indigent patients upon each specification of the second amended statement of charges of which respondent was found guilty, said suspensions to run concurrently and said public service to be imposed concurrently and to total 100 hours, that execution of said suspensions be stayed, and respondent be placed on probation for five years under the terms prescribed by the Regents Review Committee which include, among other things, monitoring of respondent's practice in the areas of thoracic and pulmonary surgery, and requiring respondent to obtain the consultation of an oncologist before proceeding with thoracic or pulmonary surgery for any malignant disease;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of

the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 6th day of August, 1990.

Thomas Sobol

Commissioner of Education