NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

January 8, 2018

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Paul Tsui, Esq.
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

James Lantier, Esq.
Smith Sovik Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, New York 13202

RE: In the Matter of Mohamed Khalaf, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 18-006) 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.

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 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
Office of Professional Medical Conduct
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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

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

In the matter of **Mohamed Khalaf, M.D.** regarding charges of professional misconduct in violation of NYS Education Law 6530.	**Determination and Order** BPMC-18-006

Before a committee on professional conduct:

William P. Dillon, M.D., Chair
Edmund A. Egan, M.D.
Dennis P. Zimmerman, M.S.

Jude Brearton-Mulvey, Administrative Law Judge

Held at: New York State Department of Health
584 Delaware Avenue
Buffalo, New York 14202
August 21, 22, September 19, 20, 2017
Briefs: November 17, 2017
Deliberations: December 28, 2017

Parties: New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2512,
Empire State Plaza
Albany, New York 12237
By: Paul Tsui, Esq.

Mohamed Khalaf, M.D.
By: James Lantier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, New York 13202

JURISDICTION

As is set forth in Public Health Law 230(1)&(7) and Education Law 6530, the legislature created the State Board for Professional Medical Conduct (the Petitioner) in the Department of Health, and authorized it to conduct disciplinary proceedings in matters of professional medical conduct.

A notice of hearing and statement of charges, both dated June 26, 2017, were served on Mohamed Khalaf, M.D. (The Respondent). (Exhibit 1.) A hearing before a committee on professional conduct was scheduled pursuant to PHL 230(10) and hearing procedures set forth in Department of Health regulations at 10 NYCRR Part 51. The burden of proof is on the Petitioner. 10 NYCRR 51.11(d)(6).

SUMMARY

The charges arise from the Respondent's medical treatment of two patients (patients A and B) in Lockport, New York, where he maintained an office for gynecological and obstetrical care. The Petitioner alleges the Respondent provided inadequate prenatal and obstetrical care to these patients.

The statement of charges included nine factual allegations in support of seven charges of misconduct. (Exhibit 1.) The Petitioner charged gross negligence and gross incompetence regarding both patient A and patient B; negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain records with regard to both patients; and improper delegation of professional responsibilities and fraudulent practice with regard to patient A. The Respondent denies any inappropriate care or recordkeeping.

In this decision, the Hearing Committee unanimously sustains all factual allegations in the statement of charges. The Hearing Committee unanimously sustains all charges of

misconduct with the exception of specifications one and three, gross negligence and gross incompetence with regard to patient A. The Hearing Committee determined that the appropriate penalty is revocation of the Respondent's license to practice medicine.

EVIDENCE

A pre-hearing conference pursuant to 10 NYCRR 51.9(c)(9) was held on August 4, 2017.

Witnesses for the Petitioner:	Patient B Patient A Mary Ann Hawkes, R.N. Rita Heary, R.N. Michele Tomkinson Kenneth Baker, M.D. Sandra Machelski, R.N.
Petitioner exhibits:	Exhibits 1-24
Witnesses for the Respondent:	Mohamed Khalaf, M.D. Gil Farkash, M.D.
Respondent exhibits:	Exhibits A-D
ALJ exhibits:	ALJ I

A transcript of the proceedings was made. (Prehearing conference transcript, pages 1-36; Hearing transcript, pages 1-611.) Each side submitted one post hearing brief.

FINDINGS OF FACT

All findings were made upon unanimous vote of the Hearing Committee.

1. Respondent Mohamed Khalaf, M.D. was authorized to practice medicine by the New York State Education Department on March 6, 1996 under license number 202334. (Exhibit 2.) During the period under review, the Respondent practiced in Lockport, New York.

Patient A. (Exhibits 8-9.)

2. The Respondent provided gynecological and obstetrical care to patient A from February 2011 through July 2013 at his office and at Eastern Niagara Hospital, both in Lockport, New York. (Exhibits 8, 9.)

3. Patient A, a 16-year old juvenile diabetic female, was admitted to Eastern Niagara Hospital on the morning of December 29, 2012, in early labor at 23 weeks gestation. (Exhibit 9, page 38; Transcript, pages 67, 338-41.)

4. The Respondent came to the hospital and examined the patient at 1:40 p.m. (Exhibit 9, pages 20, 39; Transcript, page 177.)

5. The Respondent ordered Pitocin to induce delivery of what was expected to be a nonviable fetus, but did not stay to attend the delivery. (Transcript, pages 170, 200, 343-45, 348.) He issued postpartum orders at 2 p.m., before the delivery took place. (Exhibit 9, page 18; Transcript, pages 182-83, 345.) He instructed nursing staff to handle the delivery, which they completed at 4:45 p.m. (Exhibit 9, page 39; Transcript, pages 68-69, 80-81, 97, 107, 348-49, 352.) The child was pronounced dead at 5:30 p.m. (Transcript, pages 350, 600; Exhibit 9, page 22.)

6. The Respondent visited patient A several hours after the delivery on December 29. (Transcript, pages 69-71, 592.) He did not document the visit or conduct any examination of the patient. (Transcript, pages 600-01.)

7. On December 30, 2012, at 10 a.m., the Respondent issued a telephone order to nursing staff to discharge patient A. (Exhibit 9, page 19; Transcript, pages 195, 354-55.) The patient was discharged at 10:35 a.m. (Exhibit 9, page 76; Transcript, page 355.)

8. The Respondent entered a discharge note in patient A's hospital record that documented a purported examination by him at an undocumented time on December 30. (Exhibit 9, page 22.) The Respondent did not visit or examine patient A on December 30. (Transcript, pages 356-57, 373.)

Patient B. (Exhibits 10-14.)

9. The Respondent provided prenatal and obstetrical care to patient B, a 27-year old female with a history of obstetrical complications, at his office and at Eastern Niagara Hospital between June and November 2013. (Exhibit 10, page 8; Transcript, pages 32, 224.)

10. On October 16 and November 13, 2013 office visits, patient B had 2+ urine glucose. (Exhibit 10, page 8; Transcript, page 226.) The Respondent failed to adequately test, evaluate, or manage the patient for high blood sugar during these office visits. (Transcript, pages 231-36.)

11. On November 8, a one hour glucose tolerance test showed a fasting glucose measurement of 241 and a one hour glucose measurement of 358. (Exhibit 10, page 41.) The Respondent failed to adequately manage and treat patient B for gestational diabetes. (Transcript, pages 231-33, 579-81.)

12. Respondent failed to monitor patient B's blood sugar from November 8 to November 27. (Transcript, pages 231-33; Exhibit 10.)

13. On a November 27, 2013 office visit, patient B complained of abdominal pain, nausea and vomiting. (Exhibit 10B; Transcript, pages 36, 240.) She had also lost fifteen pounds in the last two weeks. (Transcript, pages 238-39.) Respondent failed to test blood sugar levels and failed to adequately evaluate patient B for these complaints. (Transcript, pages 241-42, 284-85.)

14. On the morning of November 28, 2013, patient B presented at and was admitted to Eastern Niagara Hospital at 10 a.m. with fever, chills, abdominal pain, nausea, and vomiting. (Exhibit 11, page 46; Transcript, pages 37, 54, 114, 242-43.) The Respondent was notified of this at 10:05 a.m., but failed to adequately attend to or evaluate patient B and failed to timely order appropriate laboratory bloodwork to check patient B's blood sugar. (Transcript, page 244.)

15. The Respondent left it to hospital staff to conduct necessary evaluation and testing, without checking to ensure that they did. He did not order necessary blood tests until 12:05 p.m. (Transcript, pages 121, 246.) This was not timely. (Transcript, pages 245, 255.) Patient B had a blood sugar level of 554. (Exhibit 11, page 28; Transcript, pages 125, 246, 413.) At 2:37 p.m. nursing staff advised the Respondent that the patient was "very sick" and that he needed to come in, and he said he would. (Transcript, page 249; Exhibit 11, page 48.)

16. By the time Respondent arrived at the hospital patient B had been transferred to the hospital's intensive care unit. (Transcript, pages 128-33.) She was then transferred to Women and Children's Hospital of Buffalo, where she was found to be in diabetic ketoacidosis, and then to Millard Fillmore Hospital. (Transcript, pages 251-52; Exhibit 12, page 21.) The Respondent delivered Patient B by caesarian section at Millard Fillmore Hospital on November 29, and the child died about four hours later. (Exhibit 14, pages 10-13; Transcript, pages 42, 252-54.)

DISCUSSION OF FACTUAL ALLEGATIONS

Patient A (Exhibits 8-9.)

Allegation A1. The Hearing Committee agreed with Dr. Baker's testimony and opinion that a physician is expected to be present for delivery by his patient when there is no

reason not to be there. This was especially true with this patient, a 16-year old diabetic presenting a risk of bleeding and other injuries. (Transcript, pages 188-90, 194.) The Respondent's witness, Dr. Farkash, testified failure to be there was not improper (Transcript page 423), but his testimony was carefully qualified:

> I'm not aware that there's a standard of care specifically relating to this situation, but secondly, more importantly,... there is nothing, in standard of care that I'm aware of, that necessitates a physician to be present for the delivery as long as everybody is in agreement. (Transcript pages 423-24.)

There is no credible evidence that anyone other than the Respondent, let alone "everybody," was in agreement with his decision not to come in for the delivery. The Respondent's undocumented claims that he discussed it with the family and they agreed, are not credited. (Transcript, pages 591, 596.) Even if he did discuss it with family, it was inappropriate to put them in a position of feeling compelled to disagree with the physician responsible for patient A's well-being if they wanted him there.

The nursing staff had not seen a physician who was notified and able to appear for delivery fail to do so. (Transcript, pages 98-99, 351.) The Respondent's undocumented claim that he explained to the patient and nursing staff that he was "only 5 minutes away" and readily available, is not credited nor, more importantly, is it acceptable. (Transcript, pages 445-47, 608.) It is clear, as Dr. Baker said "This appears to be an intentional decision not to show for the delivery, as documented in the medical record." (Transcript, page 192.) The Hearing Committee concluded that the Respondent should have been there, had no good excuse not to be there, and that his actions constituted a violation of his professional responsibilities.

Allegations A2-3. Respondent claims he did visit and examine patient A at the hospital the next day, December 30, 2012, as is evidenced by a discharge note he entered in

the patient record. (Exhibit 9, page 22.) The note is dated December 30, but unlike all the Respondent's other notes, does not record the time. The Petitioner alleges that he did not in fact visit that day or examine the patient before discharge, and that the note is for that reason an inaccurate patient record. The Hearing Committee agreed the Petitioner's evidence proved the allegation.

It is undisputed that the Respondent telephoned in on the morning of December 30 at 10 a.m. to order the patient's discharge. (Exhibit 9, page 19; Transcript, page 355.) Nurse Machelski, who took the telephone discharge order at 10:00 a.m., testified that she was there from 7 a.m. until the 10:35 discharge and did not see the Respondent there. (Transcript, pages 356-57.) The Respondent nevertheless claims he was there sometime between 10 and 10:35 a.m., examined the patient, and wrote a discharge note which does not document a time. (Exhibit 9, page 22; Transcript, pages 597-99.) In explanation of his claim that he telephoned in the discharge order, and then came in to see the patient, conducted an examination and wrote a discharge note within half an hour, the Respondent testified he was at the hospital that morning, December 30, 2012, on his regular Monday surgery. December 30, 2012 was a Sunday. (Transcript, pages 593, 598.) Nurse Machelski's testimony that he was not there that morning is credited. (Transcript, pages 356-57, 373.)

The Respondent points out that Nurse Machelski, who took the Respondent's telephone discharge order at 10 a.m. on December 30, did not document a discharge physical examination. The Respondent argues that "logically, she would not have to do that if Dr. Khalaf had performed that function." (Respondent brief, page 11.) This "logic" does not lead to the conclusion that Dr. Khalaf indeed had performed that function. Nurse Machelski was asked on cross examination:

Q. Under normal circumstances in the hospital, if a physician has done a discharge physical examination, does the nurse necessarily do a physical examination for discharge purposes?

A. For discharge purposes, no. (Transcript, page 362.)

She was not asked what she would do if the physician had not documented a discharge physical examination but had issued a telephone discharge order.

Nurse Machelski described at the hearing how she received the telephone discharge order and carried it out. Her actions on that day included appropriate medical examination and were not predicated on the existence of any documented examination by the Respondent. (Transcript, pages 355-56, 358-62.) She was not even asked whether the manner in which she proceeded suggests that a discharge physical examination by the Respondent was in the chart.

The discharge note the Respondent claims he wrote sometime between 10 and 10:35 a.m. is on the same page and directly after an entry in a different hand dated December 29 at 5:30 p.m. (Exhibit 9, page 22; Transcript, page 599.) It is possible that the Respondent wrote the note after 5:30 p.m. on December 29, although he denies doing so. (Transcript, page 600.) It is more likely he wrote the note just as he testified he did, when he was at the hospital on his regular Monday surgery round. That was Monday, December 31. Either way, the preponderance of the evidence establishes that he did not examine patient A and write the discharge note on December 30 before she was discharged.

Allegation A4. The Respondent's falsification of the December 30 note clearly constituted a failure to maintain records that accurately reflected his care and treatment of the patient.

Contrary to the Respondent's claims in the brief (Respondent brief, pages 5-7), none of the charges, and none of the Hearing Committee's conclusions, depend upon any finding that Patient A was "abandoned" within the meaning of Ed.L 6530(30) on December 29 2012. The statement of charges does not allege a violation of that statute, and so it has not been considered.

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegation A1. Sustained.

Factual allegation A2. Sustained.

Factual allegation A3. Sustained.

Factual allegation A4. Sustained.

Patient B (Exhibits 10-14.)

Allegation B1-a. On October 16 and November 13, 2013 office visits, patient B's urine glucose was a significantly elevated 2+. (Exhibit 10, page 8; Transcript, pages 225-26.) Dr. Baker's opinion that blood sugar testing and screening for diabetes was necessary is credited. (Transcript, pages 228, 232.)

Regarding the October 16 visit, Dr. Farkash claimed that at 23 weeks gestation on October 16, urine glucose did not require testing up to that point. (Respondent brief, page 12; Exhibit 10, page 10; Transcript, pages 472-73.) Dr. Farkash discounted the pertinent fact that it was at 2+ on October 16, and essentially blamed patient B for not being compliant about previous testing. (Transcript, page 473-75.) The Respondent's excuse that he had ordered such testing twice in the past and the patient had not complied is no excuse at all for

his inadequate management of patient B on October 16. (Transcript, page 260; Respondent brief, page 13.)

On the November 13 visit, the Respondent had received test results ordered on November 8. (Exhibit 10, pages 10, 41; Transcript, pages 234-36.) He diagnosed, but also claims that she was not at all symptomatic of, gestational diabetes. (Transcript, pages 323, 396, 553; Exhibit 10, page 41.) Patient B needed far more aggressive and immediate management and treatment for her very high blood sugar levels, including daily blood sugar testing, than was given by the Respondent.

Allegations B1-b&c. The blood testing done on November 8, 2013 showed very high glucose levels. (Exhibit 10, page 41.) The Hearing Committee agreed with Dr. Baker that the Respondent's failure to prescribe insulin, perform needed tests and give necessary instruction in response to these alarming levels was a severe deviation from the appropriate standard of care. (Transcript, pages 230-32.) Respondent's own expert witness Dr. Farkash testified he had never seen glucose as high as shown on November 8, and that the 3-hour glucose testing the Respondent did document should be done would have no medical value. (Transcript, pages 502-503, 517.)

The Respondent argued insulin was only the "ideal treatment" and that metformin was acceptable. (Transcript, pages 235, 402, 476, 557-58.) His claim that he discussed injectable insulin, and that the patient rejected it, is not documented and is not credited. The Respondent claims he prescribed metformin, told the patient to get a glucometer, ordered a glucometer, and gave diet and other counselling. (Transcript, pages 323-25, 396-98; Exhibit 10B.) It is not documented either that he ordered a glucometer or advised her about the importance of daily testing. There is no evidence a glucometer order was filled by the

patient's pharmacy and Patient B testified she did not obtain one until after she left the hospital. (Transcript, pages 34, 378.)

The Respondent's witness, Dr. Farkash, testified on the assumption that the Respondent discussed all these matters with the patient, prescribed a glucometer and explained the need for fingerstick testing and insulin, which the patient rejected. (Transcript, pages 474-78; Exhibit 10B.) These assumptions are not consistent with the evidence. The Respondent's failure to ensure daily blood testing was done, leaving the patient on her own to understand that, was a severe deviation from the appropriate standard of care. (Transcript pages 236-37.)

The Respondent claimed that the deficiencies in his management of this patient are addressed by what can be "inferred" from his chart, and what is "implied" by what he did document. His claims are not credited as establishing either that he documented or that he took the appropriate steps. (Transcript, pages 323-25, 556-58, 561, 576-77.) The Respondent failed to document even such routine information as vitamins because it is "implied." (Transcript, page 555.) Assumptions made by Dr. Farkash to excuse the Respondent's conduct are not documented or credited. (Transcript, page 476.) Even Dr. Farkash agreed these matters should be documented. (Transcript, page 503.)

This patient needed to be placed under careful observation and management. She needed proper instruction in all aspects of her diabetic management, including proper diet, use of a glucometer, frequent reporting of daily blood sugars, and probably insulin. The blood sugar monitoring from November 8–27 was egregiously inadequate. The Respondent's claim (Respondent brief, page 15) that the patient was not compliant is an

inadequate excuse for his failure to adequately manage her care. (Transcript, pages 312-15, 566.)

Allegation B1-d. On a November 27, 2013 office visit patient B complained of pain, nausea and vomiting, and had lost fifteen pounds in two weeks. (Exhibit 10B.) The Respondent simply relied on her telling him "she was getting better," took her word for it that she was complying with all recommendations he made, and assumed that because she said her symptoms were getting better, no further action was necessary. (Transcript, pages 541-43.) She ended up hospitalized the next day with diabetic ketoacidosis. (Exhibit 12, page 21; Transcript, pages 251-52.)

The Respondent claims that an adequate evaluation of the patient's weight loss and other symptoms is "implied" by the chart. (Transcript, pages 560-61.) He also, however, blamed the patient for not bringing her glucometer to the office, saying he could not conduct any testing because he did not have one either. (Transcript, page 542; Respondent brief, page 17.) None of this is documented. Dr. Farkash agreed the patient would have had to tell him her glucometer readings if she had any to tell, yet there is no indication she did report any readings between November 8, when he claims he ordered the glucometer, and November 27. (Transcript, pages 479-80.)

With all these issues, including pain, nausea, vomiting and weight loss, the Respondent maintains that patient B "was not exhibiting any clinical signs or symptoms of diabetic complications" (Respondent brief, page 17) and so "there were no issues to adjust any other management modalities at the time." (Transcript, page 543.) This assertion is alarmingly false. Even Dr. Farkash agreed that with the symptoms presented on November 27, diabetic ketoacidosis should have been considered. (Transcript, pages 500, 504-505.)

Allegation B2-a. After seeing the Respondent on November 27, 2013 and being sent home with little evaluation, patient B was admitted to the Eastern Niagara Hospital the next day, November 28, for worsening of the same symptoms. A hospital nurse contacted Respondent by phone at 10:05 a.m. (Transcript, pages 414, 529, 532.) He gave a few orders (Exhibit 11, page 46; Transcript, pages 243-44), but did not bother to verify what if any testing was being done, and as a result did not order any blood work until shortly after noon. (Exhibit 11, page 10; Transcript, pages 119-21, 245-46.)

The blood test results were alarming, and the patient got worse. A nurse called the Respondent at 2:37 p.m. to say the patient was "very sick." (Transcript, page 494; Exhibit 11, page 48.) She was in diabetic ketoacidosis. (Transcript, pages 246-51.) The Respondent gave instructions for a 3-hour glucose test, but was talked out of it by a nurse. (Transcript, pages 126-28, 147; Exhibit 11, page 48.) All parties, including the Respondent and Dr. Farkash, agreed such a test would have made the patient much worse. (Transcript, pages 127, 249-50, 494.) The Respondent's denial that he gave an instruction for the test, in view of the documentation and testimony of nursing staff, is not credited. (Transcript, pages 538, 570-71.)

The Respondent claims he assumed the hospital would handle things properly without him. (Transcript, pages 410-11, 530-31; Respondent brief, page 19.) He was full of criticisms of the hospital staff and blames them for poor follow up on his patient. (Respondent brief, page 19; Transcript, pages 298-99, 536.) He did not take any responsibility to ensure that was being done.

Contrary to the Respondent's claims in the brief (Respondent brief, page 5), none of the charges, and consequently none of the Hearing Committee's conclusions, depend upon any finding that Patient B should have been hospitalized on November 13, 2013.

The Hearing Committee's unanimous determination on the factual allegations set forth in the statement of charges is as follows:

Factual allegation B1-a: Sustained.

Factual allegation B1-b: Sustained.

Factual allegation B1-c: Sustained.

Factual allegation B1-d: Sustained.

Factual allegation B2-a: Sustained.

DETERMINATION ON SPECIFICATIONS OF CHARGES

The statement of charges included nine specifications of seven charges of misconduct as defined in various subsections of Ed.L 6530. (Exhibit 1.) The charges of misconduct are:

Specifications one and two. Gross negligence. The Petitioner charges that the Respondent violated Ed.L 6530(4) by practicing with gross negligence with regard to both patient A and patient B.

The Hearing Committee unanimously agreed that the practices with regard to patient A, while constituting negligence, did not rise to the level of gross negligence. The Hearing Committee unanimously agreed that the practices with regard to patient B collectively amounted to an egregious failure to monitor a patient with continuing indications of serious issues with her blood sugar levels, and did constitute gross negligence.

Specification one, gross negligence with regard to patient A, is not sustained. Specification two, gross negligence with regard to patient B, is sustained.

Specifications three and four. Gross incompetence. The Petitioner charges that the Respondent violated Ed.L 6530(6) by practicing with gross incompetence with regard to both patient A and patient B.

The Hearing Committee unanimously agreed that the practices with regard to patient A included incompetence, but did not rise to the level of gross incompetence. The Hearing Committee unanimously agreed that the practices with regard to patient B collectively demonstrated an egregious failure to understand and properly address patient B's serious issues with her blood sugar levels, and did constitute gross incompetence. His direction to a nurse to perform a 3-hour glucose test when the patient was already in diabetic ketoacidosis, was also grossly incompetent, amounting to adding fuel to an already dangerous fire.

Specification three, gross incompetence with regard to patient A, is not sustained. Specification four, gross incompetence with regard to patient B, is sustained.

Specification five. Negligence on more than one occasion. The Petitioner charges that the Respondent violated Ed.L 6530(3) by practicing with negligence on more than one occasion with regard to both patients.

The Hearing Committee unanimously agreed that the practices with regard to patient A were negligent. He owed patient A, a 16-year old diabetic, far greater attention and care than he gave, and had no good reason not to be present for her delivery. The Hearing Committee also unanimously agreed that all the allegations with regard to patient B demonstrated negligence.

Specification five, negligence on more than one occasion, is sustained.

Specification six. Incompetence on more than one occasion. The Petitioner charges that the Respondent violated Ed.L 6530(5) by practicing with incompetence on more than one occasion.

The Hearing Committee unanimously agreed that the practices with both patients constituted incompetence on more than one occasion. The Respondent failed to fulfill his responsibilities to patient A, and failed to recognize, appropriately monitor, or address patient B's blood sugar issues.

Specification six, incompetence on more than one occasion, is sustained.

Specification seven. Failure to maintain records. The Petitioner charges that the Respondent violated Ed.L 6530(32) with regard to both patients by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient.

The Hearing Committee agreed that the December 30 discharge note was inaccurate in that patient A was not examined nor was the note written that day. Regarding patient B, the Respondent repeatedly attempted to excuse serious deficiencies in his documentation by claiming that the missing information was "implied" or should be "inferred." The Hearing Committee did not find credible either his claims that things that should have been done were in fact done, or that these charts somehow document that they were done. The documentation for both patients was poor, incomplete and misleading.

The Hearing Committee unanimously agreed that the practices with both patients constituted failure to maintain records.

Specification eight. Improper delegation. The Petitioner charges that the Respondent violated Ed.L 6530(25) with regard to patient A, by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has

reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them.

The Respondent insists that he did not "abandon" patient A. (Respondent brief, page 6; Transcript, page 426.) The charge is not abandonment, it is improper delegation, and it is fully supported by the evidence. There was no compelling reason for the Respondent not to attend the delivery by his patient. It was improper delegation to leave the delivery in the hands of nurses no matter how competent the Respondent might have thought them to be. The Respondent's quibble that he did not delegate delivery to the nurses, he just told them to let the patient alone until "nature took its course" was not compelling. (Transcript, pages 588-90; Respondent brief, page 8.) He should have been there and had no good reason not to be there.

The Hearing Committee unanimously agreed that the Respondent's failure to attend patient A's delivery, leaving it to hospital nursing staff, constituted improper delegation of his professional responsibilities.

Specification nine. Fraudulent practice. The Petitioner charges that the Respondent violated Ed.L 6530(2) with regard to patient A, by practicing medicine fraudulently.

The elements of fraudulent practice are: (1) a false representation by the licensee; (2) the licensee knew the representation was false; and (3) the licensee intended to mislead through the false representation. The Hearing Committee unanimously concluded that the Respondent's falsification of a purported December 30 chart entry documenting an examination of a patient he did not see or examine that day constituted practicing medicine fraudulently. The charge of fraudulent practice is sustained.

PENALTY DETERMINATION

The Hearing Committee reviewed the penalties available to it under PHL 230-a. The Committee also considered, as part of the penalty determination only, that in 2006 the Respondent was previously suspended for five years from the practice of medicine in New York. The suspension was imposed as a result of charges that were remarkably similar to the charges in this proceeding. (Exhibit 19.)

The Respondent showed no understanding of the serious deficiencies in his care of these patients, and was unwilling and/or unable to even acknowledge these deficiencies, let alone address them. He was dishonest in his documentation and made numerous claims at the hearing about his documentation and the care that he provided that are not credible. The Hearing Committee agreed that having been given an opportunity to improve his patient care practices, he demonstrated he is not able to do so. For that reason, probation or some other penalty that might enable him to continue to practice medicine would not adequately protect the public. Accordingly, the Hearing Committee unanimously concluded that revocation of his license is the appropriate penalty.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Ed.L 6530 are sustained:

   Ed. L 6530(4). Gross negligence: Patient B.
   Ed. L 6530(6). Gross incompetence: Patient B.
   Ed.L 6530(3). Negligence, more than one occasion: Patients A & B.
   Ed.L 6530(5). Incompetence, more than one occasion: Patients A & B.
   Ed.L 6530(32). Failure to maintain records: Patients A & B.
   Ed.L 6530(25). Improper delegation: Patient A.
   Ed.L 6530(2). Fraudulent practice: Patient A.

2. The Respondent's license to practice medicine is revoked.

3. This order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required under PHL 230(10)(h)

Dated: JANUARY 4TH, 2018, New York

By: [redacted]
William P. Dillon, M.D., Chair

Edmund A. Egan, M.D.
Dennis P. Zimmerman, M.S.

APPENDIX I

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

IN THE MATTER OF MOHAMED KHALAF, M.D.	STATEMENT OF CHARGES

MOHAMED KHALAF, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 6, 1996, by the issuance of license number 202334 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided gynecological and obstetrical care to Patient A (all patients are identified in the Appendix) a 16-year old female from approximately February 8, 2011 through July 25, 2013, at his office located at 225 East Avenue, Lockport, New York (office) and Eastern Niagara Hospital, Lockport, New York ("Eastern Niagara Hospital"). The charges of misconduct relate primarily to the care and treatment of Patient A from November 28, 2012 to January 2, 2013. Patient A was admitted to the Labor and Delivery Department of Eastern Niagara Hospital at approximately 11:00 a.m. on December 29, 2012, at approximately 23 weeks gestation with recent heavy vaginal bleeding. Respondent's medical care and treatment of Patient A deviated from accepted standards of medical care, in that:

1. Respondent failed to adequately attend the delivery of Patient A's fetus and/or the placenta on or about December 29, 2012, having instructed nursing staff what to do at the time of delivery in his planned absence.

2. Respondent, following the delivery of the fetus, failed to adequately evaluate Patient A prior to her discharge from the hospital.
3. Respondent entered a "discharge note" in Patient A's record that documented a purported examination by Respondent of Patient A on December 30, 2012 even though Respondent did not examine Patient A on December 30, 2012, the day of discharge. Respondent's note was a false representation. Respondent knew it was false and intended to mislead through the misrepresentation.
4. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided prenatal and obstetrical care to Patient B, a 27-year old female with a history of obstetrical complications, at his office and at Eastern Niagara Hospital at various times from approximately June 24, 2013, to November 28, 2013. Respondent's medical care and treatment of Patient B deviated from accepted standards of care in that:

1. Respondent, during Patient B's prenatal course of care from on or about June 24, 2013 to on or about November 28, 2013, failed to adequately evaluate and/or treat Patient B's risk of developing gestational diabetes as follows:
   a. Respondent failed to adequately test Patient B for high blood sugar despite documenting that Patient B had 2+ glucose in her urine during office visits on October 16, 2013 and November 13, 2013, and/or failed to document that Respondent had so tested Patient B.
   b. Respondent failed to adequately diagnose and/or treat Patient B for gestational diabetes beginning on or about November 8, 2013, despite a one hour glucose tolerance test resulting in a fasting glucose measurement of 241 and a one hour glucose measurement of 358, and/or failed to document such diagnosis and/or treatment.
   c. Respondent failed to adequately monitor Patient B's blood sugar from November 8, 2013, to on or about November 27, 2013, and/or failed to document that he had adequately monitored her blood sugar.

d. Respondent, despite complaints from Patient B of abdominal pain, nausea and vomiting during an office visit on or about November 27, 2013, failed to adequately evaluate Patient B, including monitoring Patient B's blood sugar level, and/or failed to document such adequate evaluation.

2. Respondent, during Patient B's admission to Eastern Niagara Hospital on November 28, 2013, where Patient B was admitted at approximately 10:00 a.m. with fever, chills, abdominal pain, nausea, vomiting and extreme thirst, failed to adequately evaluate and/or treat Patient B, as follows:

   a. Respondent, despite knowing that Patient B had been admitted at approximately 10:00 a.m. on November 28, 2013, failed to adequately evaluate Patient B, failed to timely order laboratory bloodwork to check Patient B's blood sugar, and/or failed to document such adequate evaluation and/or such timely orders.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND 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, in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

2. The facts in Paragraphs B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, and/or B and B.2.a.

THIRD THROUGH FOURTH 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 as alleged in the facts of the following:

3. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

4. The facts in Paragraphs B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, and/or B and B.2.a.

FIFTH SPECIFICATION

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, in that Petitioner charges:

5. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1.a, B and B.1.b, B and B.1.c, B and B.1.d, and/or B and B.2.a.

SIXTH SPECIFICATION

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, in that Petitioner charges:

6. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1.a, B and B.1.b, B and B.1.c, B and B.1 d, and/or B and B.2.a.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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, in that Petitioner charges:

7. The facts in Paragraphs A and A.3, A and A.4, B and B.1.a., B and B.1.b., B and B.1.c., B and B.1. d, and/or B and B.2.a.

EIGHTH SPECIFICATION

IMPROPER DELEGATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(25) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them, in that Petitioner charges:

8. The facts in Paragraphs A and A.1

NINTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the professional fraudulently, in that Petitioner charges:

9. The facts in Paragraphs A and A.4.

DATE: June 26, 2017
Albany, New York

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct