



STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

July 17, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy
and Schoppmann, P.C.
420 Lakeville Road
Lake Success, New York 11042

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NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Mitchell L. Kaphan, M.D.
3612 East Tremont Avenue
Bronx, New York 10465

RE: In the Matter of Mitchell L. Kaphan, M.D.

Dear Parties :

Enclosed please find the Determination and Order (No. 98-142) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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,

A handwritten signature in cursive script that reads "Tyrone T. Butler". The signature is written in black ink and includes a stylized flourish at the end.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:lcc
Enclosure

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

COPY

**IN THE MATTER
OF
MITCHELL L. KAPHAN, M.D.**

**DETERMINATION
AND
ORDER
BFMC-98-142**

A Notice of Hearing and Statement of Charges, both dated February 25, 1998, were served upon the Respondent, **MITCHELL L. KAPHAN, M.D.** **JOHN A. D'ANNA, JR., M.D.**, Chairperson, **CAROLYN SNIPE** and **WALTER T. GILSDORF, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **EDWIN L. SMITH**, Administrative Law Judge, served as the Administrative Officer. The Department of Health appeared by **DIANNE ABELOFF, ESQ.** and **DENISE QUARLES, ESQ.**, Associate Counsel. The Respondent appeared by **LAWRENCE T. TABAK, ESQ.** Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	February 25, 1998
Answer to Statement of Charges:	March 17, 1998
Pre-hearing Conference:	March 24, 1998
Dates of Hearings:	March 27, 1998 April 17, 1998 April 27, 1998

Received Petitioner's
Proposed Findings of Fact,
Conclusions of Law and
Recommendation:

May 12, 1998

Received Respondent's
Proposed Findings of Fact,
Conclusions of Law and
Recommendation:

May 14, 1998

Witness for Department of
Health:

Seymour L. Edelstein, M.D.

Witnesses for Respondent:

Mitchell L. Kaphan, M.D.
Marc Prager, M.D.
Richard Memoli, M.D.

Deliberations Held:

May 26, 1998

STATEMENT OF CASE

The Petitioner has charged Respondent, Mitchell L. Kaphan, M.D., with eleven specifications of professional misconduct. The allegations concern Respondent's medical care and treatment of three patients at three different hospitals. More specifically, the Respondent is charged with negligence on more than one occasion, three specifications of gross negligence, incompetence on more than one occasion, three specifications of gross incompetence, and three specifications of unwarranted treatment.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. The numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Mitchell L. Kaphan, M.D. (hereinafter "Respondent") was authorized to practice medicine in New York State by the issuance of license number 139985 by the New York State Education Department. (Not contested.)
2. Respondent concedes that wrong site surgery was performed by Respondent on Patients A, B and C. (Respondent's Brief, pages 2, 4, 8 and 10.)*

Patient A

Failure to Perform Adequate Physical Examination

3. On December 18, 1995, Patient A presented to the OLMMC emergency room complaining of pain in his right groin and hip due to a fall he experienced earlier that day. X-rays taken revealed a fractured right hip. The ER admitted Patient A to the service of Respondent with a diagnosis of right intertrochanteric fracture of the hip and notified the Respondent as such. (T 145, 149, 443) (Petitioner's Exhibit 3, pages 3, 4, 7 and 11).
4. On December 18, 1995, the ER physician requested that Patient A's x-rays be taken of the right hip and pelvis. (T 206-107.) (Petitioner's Exhibit 3, pages 6, 107). The x-rays of Patient A revealed a right hip fracture. (T 145, 149, 154, 156) (Petitioner's Exhibit 3, pages 5, 6 and 11) (Petitioner's Exhibit 3b-3g.).
5. Patient A's ER x-rays were marked correctly in magic marker for the right side. (T 449-451).

* Reference to "Respondent's Brief" or to "Petitioner's Brief" references the respective parties' Proposed Findings of Fact and Conclusions of Law.

6. Respondent testified that he was also contacted with respect to Patient MG at the emergency area of OLMCC whose x-rays of Patient MG purportedly reflected a fracture of the fibula of the right ankle. (T 448-451). Respondent then viewed Patient A's x-rays and noted that again in magic marker was written "RT" and, accordingly, noted a nondisplaced fracture of the right hip. (T 449-451).
7. The Respondent then visited Patient MG and found that her left ankle had been splinted. Patient MG confirmed that it was her left ankle that had been fractured, and not her right ankle. (T 451-453).
8. Respondent had viewed the x-rays concerning Patient A and noted that it reflected a nondisplaced fracture of the right hip. Patient A's x-rays showed some rotation at the fracture site of the right hip as well as some shortening which accompanied the rotation. The ER staff noted that Patient A's right leg was shorter and the right foot externally rotated consistent with a right intertrochanteric fracture. (T 152-154) (Petitioner's Exhibit 3, pages 4, 10) (Petitioner's Exhibit 3b-3g).
9. Respondent then proceeded to examine Patient A. (T 455). When Patient A said he could not lift his left leg, Respondent claims to have rocked that knee internally and externally. (T 458). Respondent did not do any further clinical evaluation of Patient A's left side. (T 500). Respondent did not visualize either of Patient A's hips. (T 522). Respondent did not notice that Patient A's right leg was either shorter or rotated. (Petitioner's Exhibit 3, page 13).
10. Respondent was aware that Patient A was perhaps confused and may have had Alzheimer's disease. (T 181, 457, 498-499) (Petitioner's Exhibit 3, page 13). Patient A's son signed the consent form authorizing surgery on Patient A's right hip. (T 157-158) (Petitioner's Exhibit 3, page 85). Respondent did not review the consent form prior to surgery (T 482).

11. Respondent failed to perform an adequate pre-operative physical examination of Patient A. (T 151-152). Respondent failed to visualize the right hip to determine, in the case of an intertrochanteric fracture, whether the leg is shortened and externally rotated. (T 152). The physician should also record whether there is pain to slight movement, ecchymosis around the lower buttock area or, swelling. (T 152). In the case of Patient A, the x-ray showed there was rotation at the fracture site and that shortening may have accompanied the rotation. (Petitioner's Exhibit 3b, c and g) (T 153-154). There was no pathology noted on the x-rays with respect to the left hip. (T 154).
12. Respondent's testimony with respect to his findings concerning Patient A's left hip (T 458) are discounted in view of the fact that they are not reflected in the chart and the presence of radiographs showing involvement of the right hip.
13. Even giving Respondent the benefit of the doubt as to receiving conflicting history and clinical findings regarding which extremity was involved, Respondent failed to obtain adequate confirmation as to which hip required surgery. (T 154-155). Under these circumstances, the orthopedic surgeon should redo the films using lead markings if they are available to determine which hip had the pathology and to reexamine the Patient. (T 154-155). Respondent failed to do either.

Failure to Adequately Review X-rays Prior to Surgery

14. The Hearing Committee finds that the charges relating to Respondent's failure to adequately review Patient A's x-rays prior to surgery are not sustained. The Hearing Committee accepts that Respondent reviewed the x-rays and came to a proper diagnosis but he misinterpreted the labeling of the side. (T 449-450).

Failure to Obtain Confirmation of Operative Site

15. Respondent failed to obtain adequate confirmation of which hip required surgery. Respondent testified he discounted the markings on the x-rays because of problems he had had in the past with the hospital radiographic technician and the problem he experienced that same day with respect to Patient MG. In light of that discrepancy, the Respondent should have resolved the conflict between his interpretation and physical findings, on the one hand, and the x-rays and physical findings of the ER doctor, as reflected in the hospital chart. Respondent conceded that at no time prior to performing surgery on Patient A did he consider ordering new x-rays. (T 460). Both Petitioner's expert, Dr. Seymour L. Edelstein, and Respondent's expert, Dr. Richard Memoli, concurred that if there were a discrepancy between x-ray findings and the clinical evaluation, another set of x-rays should be ordered. (T 154-155 and T 554-555).

Failure to Adequately Review Hospital Record Prior to Surgery

16. Respondent failed to adequately review Patient A's hospital chart prior to surgery. Reflected in the chart is the ER record of physical examination showing that Patient A was moving the right leg with pain and that the right leg was externally rotated. (Petitioner's Exhibit 3, page 4). Moreover, under history and physical examination, the chart reflected that the right leg of Patient A was shorter and externally rotated. (Petitioner's Exhibit 3, page 10). Although Respondent claims to have made a number of findings with respect to Patient A's right side (T 458-459), none are mentioned in the chart. The chart reflects findings by disinterested parties in the persons of the radiographic technician and the emergency room physician confirming findings to Patient A's right side. Respondent's statements concerning his examination and findings relating to the right side are not reflected on the chart and were self-serving.

17. Moreover, Respondent did not ask the emergency room physician, who took the history and performed the physical, to clarify his findings nor, did he ask the hospital radiographic technician about the purported discrepancy with Respondent's clinical evaluation and the x-ray. (T 485).
18. It would appear that Respondent reviewed Patient A's hospital chart prior to surgery but came to the wrong conclusion based on incorrect assumptions, specifically with respect to the mislabeling of the x-rays. (T 502).

Patient B

Failure to Perform Adequate Pre Op Workup and Failure to Adequately Review Office and Hospital Records Prior to Surgery

19. On February 3, 1992, Respondent examined Patient B in his private office at 3612 Tremont Avenue, Bronx, New York. Patient B was referred to the Respondent by her primary physician with complaints of pain in her left knee for the previous two months. (T 88, 313) (Petitioner's Exhibit 4, page 3) (Respondent's Exhibit J). Respondent noted pain medially and posteriorly to Patient B's left knee. (T 313). No findings were made with respect to Patient B's right knee. (T 357-358) (Respondent's Exhibit J).
20. Received by Respondent from Patient B on February 3, 1992, were an MRI and report dated January 28, 1992, showing tears along the posterior aspect of the medial meniscus. Respondent made Patient B's MRI and report part of his office records. (T 313) (Respondent's Exhibit J).

21. Respondent's diagnosis of Patient B on February 3, 1992, was "tear medial meniscus left knee". Respondent scheduled Patient B for arthroscopic surgery at Westchester Square Medical Center on February 19, 1992. (T 90, 99, 116, 312-313, 361) (Petitioner's Exhibit 4, pages 2, 3). Respondent used the MRI and report to complete information on Patient B's admission form which made part of the hospital chart. (T 361-362) (Petitioner's Exhibit 4, page 3).
22. Respondent completed Patient B's consent form including the diagnosis of torn medial and lateral meniscus of the left knee and completed the procedure information reflecting arthroscopy of the left knee. (T 364-365) (Petitioner's Exhibit 4, page 15). Patient B signed her consent form, dated February 19, 1992, authorizing Respondent to operate on her left knee. (T 94) (Petitioner's Exhibit 4, page 15).
23. Respondent testified that although Patient B was originally scheduled to be his fourth procedure on February 19, 1992, he changed the schedule so that she would be his first procedure of that day. (T 317-321). After seeing her in the holding area on the morning of February 19, 1992, it was still Respondent's intention to do a left knee procedure. (T 321-322). Respondent testified that he informed Circulator Nurse Mattana Thitawathana of the change in schedule. (T 324).
24. On entering the operating room, Patient B was positioned for a right knee arthroscopy instead of a left knee arthroscopy. (T 331-332).
25. Respondent failed to review his office records or the hospital chart prior to operating on Patient B. (T 91, 95-96, 362-364). Moreover, Respondent did not review Patient B's MRI prior to operating nor were the MRI's in the operating room during surgery. (T 93, 413-414, 553).

26. Respondent incorrectly performed arthroscopic surgery on Patient B's right knee instead of on her injured left knee. (T 92, 314, 366, 398). Respondent admitted that he did not review the chart before surgery. (T 364). The hospital chart was in the operating room. (T 362-363).
27. Respondent's expert, Dr. Richard Memoli, testified that it was the responsibility of the operating room nurses, both the scrub nurse and circulating nurse, to set up the operating room and the equipment in the operating room as well as to position the patient before surgery. (T 549-550).
28. Notwithstanding, as testified to by Petitioner's expert, it is the responsibility of the operating surgeon "to make sure that the proper leg or the proper extremity is the one that is being prepped and draped". (T 95-96).
29. When Respondent realized that he had entered the wrong knee of Patient B, he proceeded to do a diagnostic and therapeutic exploration on her right knee which included shaving the medial meniscus. Those shavings were not sent to the lab for a pathology report for confirmation that the procedure was warranted. (T 372-373).
30. Respondent performed the diagnostic and therapeutic arthroscopy on Patient B's right knee without consent. (T 385-387).
31. Although Respondent testified that his clinical examination on February 3 elicited complaints of pain to Patient B's right knee (T 391), there was no record of that complaint. (T 89-90) (Respondent's Exhibit J).

Patient C

Failure to Perform Adequate Pre Operative Workup Including Failure to Review and/or Obtain Radiographic Confirmation of Which Hip Required Surgery

32. Respondent, since 1984, was the house orthopedic surgeon and ran the clinic at St. Barnabas Hospital in the Bronx. On April 1, 1987, Patient C presented to the St. Barnabas emergency room complaining of pain to her right hip. (T 22, 227). The ER x-ray revealed a fracture to the right femoral neck. (T 22, 230, 235). There was no lead marker on the x-ray but there was a "sticky" placed on the x-ray with a handwritten "R". (T 232-235, 244, 275, 304) (Petitioner's Exhibit 5, page 103).
33. Patient C was admitted to the St. Barnabas ER on April 1, 1987, and referred to the service of Respondent to repair her right hip. Patient C was scheduled for a bipolar cemented hip arthroplasty for April 2, 1987. (Petitioner's Exhibit 5, pages 10-16, 114).
34. Respondent testified as to his examination of Patient C and the history obtained from Patient C's husband and sister as well as a telephone conversation he had with Patient C's family physician, all of whom told him that the problem with Patient C was her left hip and not her right hip. (T 236-239).
35. Prior to examining Patient C, Respondent reviewed her x-rays and the ER physician's request for the x-rays which requested a pelvis AP view. The x-ray was marked correctly with a sticker denoting a right femur fracture. (T 230, 244, 275) (Petitioner's Exhibit 5, page 103). Respondent also read the notes in the hospital chart written by other physicians reflecting that Patient C had pain in her right hip. (T 235-236, 249-250) (Petitioner's Exhibit 5, pages 10, 12).

36. Respondent testified that the x-ray available to him in the emergency room was inconclusive as to which hip was injured. (T 270-271). Respondent further stated that he does not proceed with surgery without benefit of an x-ray to confirm the site of the injury. (T 271). Further, Respondent stated that he proceeded with surgery without benefit of an x-ray to confirm the injury. (T 272).
37. Although there was a discrepancy between Respondent's evaluation and the x-rays, Respondent did not take a new x-ray to resolve the discrepancy. (T 24-26, 259-260, 275-276).
38. Petitioner's expert, Dr. Edelstein, testified that under those circumstances, the physician must resolve the discrepancy by taking another set of x-rays or by having other tests performed such as a bone scan or tomogram. (T 26).
39. Patient C's x-ray was on the view box in the operating room at the beginning of surgery. (T 246). However, Respondent failed to review the x-ray or to obtain adequate radiographic confirmation of which hip required surgery. (T 24-25, 31, 85, 259-260, 275-276, 279).
40. On April 2, 1987, Respondent incorrectly made a surgical approach down to the neck of the femur of Patient C's left hip instead of the injured right hip. (T 26, 242-243, 270-272).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation.

- A. (3-4);
- A1¹ ();
- A1a (2-13);
- A1b² ();
- A1c (2, 9-11, 15-17);
- A1d³ ();
- A2 (2-18);
- B. (19-21);
- B1⁴ ();
- B1a (19-31);
- B1b (19-31);
- B2 (2, 19-31);
- C. (33-34);
- C1⁵ ();
- C1a (33-41);
- C2 (2, 33-41).

¹ Paragraphs A1, B1 and C1 are prefatory to the Factual Allegations that follow and are, therefore, not separately treated.

² Paragraphs A1b and A1d are not sustained.

³ *Ibid.*, footnote 2.

⁴ *Ibid.*, footnote 1.

⁵ *Ibid.*, footnote 1.

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:⁶

FIRST SPECIFICATION - Negligence on more than one occasion: (paragraphs A, A1a, A1c, A2, B, B1a, B1b, B2, C, C1a and C2);

SECOND SPECIFICATION - Gross negligence as to Patient A: (paragraphs A, A1a, A1c and A2);

THIRD SPECIFICATION - Gross negligence as to Patient B: (these charges are not sustained);

FOURTH SPECIFICATION- Gross negligence as to Patient C: (these charges are not sustained);

FIFTH SPECIFICATION - Incompetence on more than one occasion: (paragraphs A, A1a, A1c, A2, B, B1a, B1b and B2);

SIXTH SPECIFICATION - Gross incompetence as to Patient A: (these charges are not sustained);

SEVENTH SPECIFICATION - Gross incompetence as to Patient B: (these charges are not sustained);

⁶ *Ibid.*, footnote 1.

EIGHTH SPECIFICATION - Gross incompetence as to Patient C: (these charges are not sustained);

NINTH SPECIFICATION- Unwarranted treatment as to Patient-A: (these charges are not sustained);

TENTH SPECIFICATION - Unwarranted treatment as to Patient B: (paragraphs B1a, B1b and B2);

ELEVENTH SPECIFICATION - Unwarranted treatment as to Patient C: (these charges are not sustained).

DISCUSSION

Respondent is charged with eleven Specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg, Esq., General Counsel for the Department of Health, dated January 9, 1996. This document, entitled "Definitions of Professional Misconduct under the New York Education Law", sets forth suggested definitions for negligence, gross negligence, incompetence and gross incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice a profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of a profession.

Unwarranted Treatment is the ordering of excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient. (Education Law § 6530(35)).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Petitioner has sustained its burden of proof regarding serious charges brought against Respondent. The rationale for the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the various witnesses presented by the parties. The Petitioner presented one expert witness, Dr. Seymour L. Edelstein. Dr. Edelstein is Board certified in orthopedics who is engaged in private practice in Brooklyn and Staten Island, New York.

The Respondent presented Dr. Marc Prager, who is Board certified in nuclear medicine and has been in private practice from 1987 with University Diagnostic Medical Imaging, a five doctor radiology practice serving the five boroughs of New York City and lower Westchester County.

The Respondent also presented Dr. Richard Memoli, who is Chief of Orthopedic Surgery at Westchester Square Hospital.

None of the witnesses has a demonstrated stake in the outcome of this case. However, both Drs. Memoli and Prager have known the Respondent for several years and have worked with him. The Hearing Committee notes that all the expert witnesses are highly qualified in their respective areas of practice.

The Hearing Committee's determination regarding the credibility of these witnesses rested on the quality of their testimony. Dr. Edelstein was unequivocal in his criticism of Respondent by

reason of his failure to resolve obvious discrepancies in Respondent's evaluation as opposed to diagnostic tests (in particular x-rays), history and clinical evaluations by other physicians. Dr. Edelstein pointedly indicated that Respondent's failure in each case to resolve obvious discrepancies before performing surgery was at the core of the repeated wrong site surgeries. Respondent's experts sought to assist Respondent by implicating the conduct of others, such as the x-ray technician or the operating room nurses, but even Dr. Memoli had to agree that faced with a discrepancy such as confronted Respondent, he would have additional x-rays taken of the patient before performing surgery. On balance, the Hearing Committee determined that greater weight would be placed on the opinions expressed by Dr. Edelstein.

Respondent testified on his own behalf. While conceding wrong site surgery with respect to patients A, B and C, respondent sought to implicate the conduct of others as contributing factors. With respect to Patients A and C, Respondent's diagnoses differed from that of the x-ray findings as well as the findings by emergency room physicians. Even assuming that there was reason to question the x-rays as well as emergency room diagnosis, Respondent failed to take appropriate steps to resolve those discrepancies. In particular, he failed in both cases to order additional x-rays of the patients. Even his own expert readily admitted that he would have ordered new x-rays in order to resolve such a discrepancy prior to surgery. As to Patient B, Respondent sought to implicate the conduct of the operating room nurses. The Hearing Committee is not dissuaded as it is the surgeon who has the ultimate responsibility to confirm the operative site.

Negligence and Incompetence

Petitioner charged Respondent with three specifications of gross negligence, three specifications of gross incompetence, negligence on more than one occasions and, incompetence on more than one occasion. The evidence clearly establishes that Respondent repeatedly failed to perform and/or record adequate physical examinations and failed to resolve discrepancies between Respondent's diagnosis as opposed to x-ray reports and emergency room findings. Moreover, the

Hearing Committee was impressed with the Respondent's failure to resolve apparent discrepancies prior to surgery especially having had the experience of previous wrong site surgery.

Negligence has been defined as a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. The Hearing Committee unanimously concluded that Respondent's failure to meet the standards of practice for his field was clearly demonstrated with regard to Patients A, B and C. Therefore, the Committee voted to sustain the First Specification of negligence on more than one occasion.

Gross Negligence has been defined as an egregious failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. The Hearing Committee unanimously concluded that Respondent's failure to meet the standards of practice for his field were so egregious as to constitute gross negligence with regard to Patient A. Therefore, the Committee voted to sustain the Second Specification (gross negligence). Having had two prior wrong site surgical experiences, and having failed to take remedial steps to effectively prevent a reoccurrence, the Committee felt that Respondent's course of conduct with respect to Patient A amount to gross negligence. The Hearing Committee unanimously voted not to sustain the Third and Fourth Specifications as to Patients B and C.

Incompetence has been defined as a lack of the skill or knowledge necessary to practice a profession. The Hearing Committee unanimously concluded that Respondent's conduct with regard to Patients A and B met this definition. Having previously experienced wrong site surgery with respect to Patient C, it was incumbent upon Respondent to have resolved the discrepancies between his diagnosis of Patient A and that revealed by the x-ray and emergency room physician prior to surgery. Insofar as Patient B is concerned, Respondent failed to adequately review his records and those contained in the hospital chart prior to surgery and the fact that operating room personnel may have inappropriately prepped Patient B for surgery does not take away from the Respondent's ultimate responsibility to confirm the operative site prior to surgery. Accordingly, the Hearing Committee voted to sustain the Fifth Specification (incompetence on more than one occasion).

Gross incompetence has been defined as an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of the profession. The Hearing Committee determined that Respondent's conduct does not meet this definition. The Committee determined that Respondent does have the appropriate surgical skills but is in need of a monitoring physician to supervise Respondent's preoperative procedures so as to prevent a reoccurrence of the problems Respondent has occasioned in the past. Accordingly, the Hearing Committee voted not to sustain the Sixth, Seventh and Eighth Specifications.

Respondent was also charged with committing professional misconduct as defined in Education Law Section 6430(35) by performing professional services not warranted by the condition of the patient. The subparagraph in question references "ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient". The Hearing Committee unanimously concluded that Respondent's conduct with regard to Patient B met this definition. Having realized that he was operating on the wrong knee, Respondent should have immediately ceased any further surgical intervention especially in light of there being no history of any complaints with respect to that knee and the failure of the Respondent to submit the shavings for a pathological study. The Hearing Committee unanimously voted not to sustain those findings as to the Ninth and Eleventh Specifications regarding Patients A and C.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be suspended for one year but that the suspension be stayed. The Committee further determined that the licensee be placed on probation for five years and a practice monitor be assigned to pre-operatively review all respondent's surgical cases. Public Health Law, Section 230(18)(a)(iii); *Caselnova v. New York State Department of Health*, 1998 WL217970 (N.Y.) (New York Court of Appeals, May 5, 1998).

The evidence produced during this hearing provided conclusive proof of a repeated pattern of conduct on the part of the Respondent whereby preoperative practices and procedures were found lacking. This inadequate preoperative preparation and the failure of the Respondent to resolve discrepancies prior to surgery have led to a series of wrong site surgeries. Notwithstanding, there is ample evidence that Respondent possesses the appropriate skills and knowledge to continue practicing medicine under appropriate safeguards.

ORDER

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

1. That the First, Second, Fifth and Tenth Specifications of professional misconduct as set forth in the Statement of Charges (Petitioner's Exhibit "1") are **SUSTAINED**;

2. The Third, Fourth, Sixth, Seventh, Eighth, Ninth and Eleventh Specifications of professional misconduct are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is suspended for one year commencing on the effective date of this Determination and Order which suspension is hereby **STAYED**;

4. Respondent is placed on probation for five years commencing on the effective date of this Determination and Order and a practice monitor is to be assigned to preoperatively review all Respondent's surgical cases during said probation period;

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and service shall be effective upon receipt or seven (7) days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

Dated: Albany, New York
June 30, 1998



JOHN A. D'ANNA, JR., M.D. (CHAIR)
CAROLYN C. SNIPE
WALTER T. GILSDORF, M.D.

TO: Denise Quarles, Esq.
Dianne Abeloff, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza
New York, NY 10001

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3612 East Tremont Avenue
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T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy and Schoppmann, P.C.
Attorney for Respondent
420 Lakeville Road
Lake Success, NY 11042

APPENDIX I

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

IN THE MATTER
OF
MITCHELL L. KAPHAN, M.D.

NOTICE
OF
HEARING

TO: Mitchell L. Kaphan, M.D.
3612 East Tremont Avenue
Bronx, New York 10465

BY: T. Lawrence Tabak, Esq.
KERN AUGUSTINE CONROY
& SCHOPPMANN, P.C.
420 Lakeville Road
Lake Success, NY 11042

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1998) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1998). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 27, 1998, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of

Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date.

Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1998) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1998). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
February 20, 1998



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Denise L. Quarles
Attorney
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

IN THE MATTER
OF
MITCHELL L. KAPHAN, M.D.

STATEMENT
OF
CHARGES

MITCHELL L. KAPHAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 5, 1979, by the issuance of license number 139985 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. At all times herein mentioned, Respondent was a member of the orthopedic staff at Our Lady of Mercy Medical Center ("OLMMC"), Bronx, New York. On or around December 18, 1995, Patient A presented to the OLMMC emergency room complaining of pain in his right groin and hip. X-rays taken revealed a fractured right hip. The ER admitted Patient A to the service of Respondent in order to perform an open reduction and internal fixation to the right hip. (Patient A and all other patients are identified in the annexed Appendix).
During the period of treatment regarding Patient A:

1. Respondent failed to perform an adequate pre-operative work-up, including but not limited to:
 - a. Failed to perform an adequate physical examination.
 - b. Failed to adequately review Patient A's x-rays prior to surgery.
 - c. Failed to obtain adequate confirmation of which hip required surgery.

d. Failed to adequately review Patient A's hospital chart prior to surgery.

2. On or around December 19, 1995, Respondent incorrectly performed surgery on Patient A's left hip, instead of the fractured right hip.

B. At all times herein mentioned, Respondent was a member of the orthopedic staff at Westchester Square Medical Center ("WSMC"), Bronx, New York. At all times herein mentioned, Respondent also practiced from his private office located at 3612 Tremont Avenue, Bronx, New York. On or around February 3, 1992, at his private office, Respondent examined Patient B for the pain in her left knee, which she claimed she had for the past two months. Respondent diagnosed Patient B with having "tear medial meniscus left knee" and admitted her to WSMC in order to perform arthroscopic surgery on her left knee.

1. Respondent failed to perform an adequate pre-operative work-up, including but not limited to:
 - a. Failed to adequately review his office records prior to surgery.
 - b. Failed to adequately review Patient B's hospital record.
2. On or around February 19, 1992, Respondent incorrectly performed arthroscopic surgery on Patient B's right knee, instead of on the injured left knee.

C. At all times herein mentioned, Respondent was a member of the orthopedic staff at St. Barnabas Hospital, Bronx, New York. On or around April 1, 1987, Patient C presented to the St. Barnabas emergency room complaining of pain in her right hip. X-rays taken revealed a fracture of the right femoral neck. The ER admitted Patient C to the service of Respondent to repair her right hip. Respondent scheduled Patient C's surgery for the following day in order to perform a cemented bipolar hip arthroplasty. During the period of treatment regarding Patient C:

1. Respondent failed to perform an adequate pre-operative work-up, including but not limited to:
 - a. Failed to review and/or obtain adequate radiographic confirmation of which hip required surgery.

2. On or around April 2, 1987, Respondent incorrectly made a surgical approach and incision to Patient C's left hip, instead of the injured right hip.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts of paragraphs A, A1, A1a, A1b, A1c, A1d, A2, B, B1, B1a, B1b, B2, C, C1, C1a, and/or C2.

SECOND THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. The facts of paragraph A, A1, A1a, A1b, A1c, A1d, and/or A2.
3. The facts of paragraph B, B1, B1a, B1b, and/or B2.
4. The facts of paragraph C, C1, C1a, and/or C2.

FIFTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

5. The facts of paragraph A, A1, A1a, A1b, A1c, A1d, A2 , B, B1, B1a, B1b, B2, C, C1, C1a, and/or C2.

SIXTH THROUGH EIGHTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

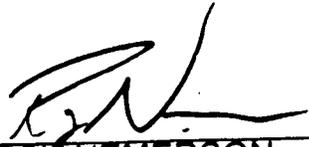
- 6 The facts of paragraph A, A1, A1a, A1b, A1c, A1d, and/or A2.
7. The facts of paragraph B, B1, B1a, B1b, and/or B2.
8. The facts of paragraph C, C1, C1a, and/or C2.

NINTH THROUGH ELEVENTH SPECIFICATIONS
UNWARRANTED TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by performing professional services which were not warranted by the condition of the patient.

9. The facts of paragraph A and/or A2.
10. The facts of paragraph B and/or B2.
11. The facts of paragraph C and/or C2.

DATED: February 25, 1998
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct