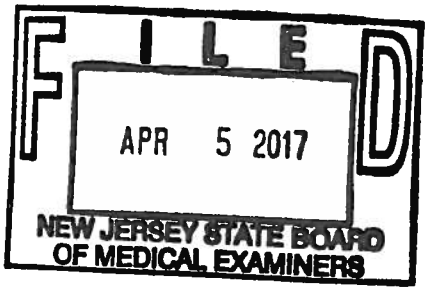


STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:

THOMAS J. KAYAL, M.D.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon receipt of a report from the Medical Practitioner Review Panel (the "Panel") detailing findings and recommendations made at the conclusion of the Panel's investigation of medical care and treatment provided by respondent Thomas J. Kayal, M.D. to patient P.M. The Panel commenced its investigation upon receipt of a malpractice payment report, detailing that a payment of $775,000 had been made on respondent's behalf to settle a civil malpractice action brought against him by P.M. In that action, it was alleged that respondent failed to follow-up on pathology results that revealed cancer after he had performed a colonoscopy on P.M., which in turn led to a delay in the diagnosis of P.M.'s colorectal cancer.

In the course of its investigation, the Panel reviewed hospital records for patient P.M., respondent's office records, and expert reports prepared during the pendency of the malpractice action. The Panel additionally considered testimony offered by

respondent when he appeared before the Panel, *pro se*, for an investigative hearing on December 16, 2016.

Upon review of available information, the Panel found that respondent saw P.M., a 55 year old woman, for complaints of abdominal pain and rectal bleeding on August 12, 2009. P.M.'s medical history revealed a family history of colon cancer. Respondent recommended that P.M. have a diagnostic colonoscopy to evaluate her persistent rectal symptoms.

Respondent performed a colonoscopy on P.M. on September 17, 2009 at Virtua Hospital. During the procedure, respondent identified internal hemorrhoids associated with a sessile polyp in the mid-rectum. Respondent removed the polyp and submitted the specimen for pathologic analysis. P.M. was discharged from the hospital on September 17, 2009.

On September 18, 2009, pathology diagnosed the polyp to be a moderately differentiated adenocarcinoma arising within a tubular adenoma. On October 6, 2009, respondent entered a progress note in P.M.'s hospital chart directly documenting the finding of adenocarcinoma made in the pathology report. Despite entering that chart note, respondent never advised P.M. of the finding of adenocarcinoma that had been made.

Respondent thereafter had no further contact with P.M. until he saw her in his office on August 23, 2010, approximately eleven months after the colonoscopy had been performed. At that

visit, respondent diagnosed P.M. with hemorrhoids and prescribed steroid suppositories, however he once again failed to inform her of the finding of cancer that had been made following the September 2009 colonoscopy. Additionally, respondent did not then recommend that P.M. schedule a repeat colonoscopy.

P.M. ultimately had a repeat colonoscopy performed by another physician on April 27, 2011. Following that procedure, she was found to have an invasive carcinoma of the mid-rectum, and she commenced receiving treatment for colon cancer.

When appearing before the Panel, respondent testified that he was aware of the pathology findings that had been made following the colonoscopy, but did not specifically advise P.M. of those findings because he considered the pathology findings to be "benign." Respondent further testified that he was confident that he had removed the entirety of the rectal polyp at the time of the colonoscopy. Respondent maintains that, after completing the colonoscopy, he advised P.M. generally that she would need to see him again in "about" a year, but there is no documentation in either respondent's medical record or the hospital chart which memorializes respondent's having advised P.M. to have a repeat colonoscopy within one year. Further, although respondent entered a note in P.M.'s hospital chart on October 6, 2009 documenting the pathology findings, he failed to record the pathology findings in

his office medical record, and he failed to obtain and/or maintain a copy of the pathology report in his office record.

The Panel found that respondent's failure to have advised P.M. that the polyp removed during the colonoscopy was found to be cancerous constituted an act of negligence.[1] Additionally, the Panel found that his subsequent failure to have communicated that finding directly to P.M., when he next saw P.M. in his office on August 23, 2010, constituted an independent act of negligence.

The Panel additionally found that respondent violated provisions of the Board's Record Keeping regulation, N.J.A.C. 13:35-6.5, by: (1) failing to document, either in the hospital chart or in his office record, that he advised P.M. to have a repeat colonoscopy performed within one year of the date on which the original colonoscopy was performed; and (2) by failing to have documented the pathology findings of adenocarcinoma in his office record (or, in the alternative, by failing to have obtained and/or maintained a copy of the pathology report in his office chart). The Panel thus found that bases for disciplinary action against respondent exist pursuant to N.J.S.A. 45:1-21(d) and 45:1-21(h).

The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board being satisfied that good cause exists for the entry of this Order,

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[1] The Panel specifically found that even if respondent thought that the polyp was "benign," he had an absolute obligation to advise his patient of the findings that had been made, and his failure to have discharged that obligation constituted negligence.

IT IS on this 5th day of April, 2017

ORDERED and AGREED:

1. Respondent Thomas J. Kayal, M.D., is hereby formally reprimanded for having engaged in repeated acts of negligence, and for having violated requirements of the Board of Medical Examiners' Record Keeping regulation, in connection with his care and treatment of patient P.M., as more fully detailed above.

2. Respondent is assessed a civil penalty in the amount of $5,000, which penalty shall be payable in full, by certified check or money order (or by any alternative payment method deemed acceptable by the Board) at the time of entry of this Order.

3. Respondent shall, within six months of the date of entry of this Order, take and successfully complete courses in medical record keeping and medical ethics. Respondent may satisfy the requirements of this paragraph by completing any ethics and/or medical record keeping course(s) that is presently approved by the Board (a list of such courses has been made available to respondent). Alternatively, respondent shall be required to secure written pre-approval from the Medical Director of the Board for any course he may propose to take to satisfy the requirements herein, which he may seek by providing all available information concerning any proposed course to the Medical Director of the Board. The Medical Director shall review said information and determine whether the proposed course is or is not acceptable to the Board.

Respondent shall be responsible to ensure that documentation of successful completion of the courses taken to satisfy the requirements of this paragraph is forwarded by the course provider(s) to the Board. In the event that respondent fails to successfully complete the course work required herein in a timely fashion (that is, in the event the Board does not receive documentation of successful completion of approved courses within six months of the date of entry of this Order), respondent shall be deemed to have failed to comply with the requirements of this Order, and his license may then be immediately suspended by the Board for failure to comply with the terms of this Order. In the event an Order of immediate suspension for failure to comply with the terms of this Order is entered, respondent's license shall thereafter continue to be actively suspended until such time as he successfully completes the required course work, documentation

thereof is submitted to the Board, and written notice of reinstatement is provided by the Board to respondent.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: _____
George J. Scott, D.O., D.P.M.
Board President

I represent that I have carefully read and considered this Order, understand its terms, agree to comply with those terms and consent to the entry of the Order by the Board.

_____
Thomas J. Kayal, M.D.

Dated: 3/31/17

# NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ORDERS/ACTIONS

All Orders filed by the New Jersey State Board of Medical Examiners are "government records" as defined under the Open Public Records Act and are available for public inspection, copying or examination. See N.J.S.A. 47:1A-1, et seq., N.J.S.A. 52:14B-3(3). Should any inquiry be made to the Board concerning the status of a licensee who has been the subject of a Board Order, the inquirer will be informed of the existence of the Order and a copy will be provided on request. Unless sealed or otherwise confidential, all documents filed in public actions taken against licensees, to include documents filed or introduced into evidence in evidentiary hearings, proceedings on motions or other applications conducted as public hearings, and the transcripts of any such proceedings, are "government records" available for public inspection, copying or examination.

Pursuant to N.J.S.A. 45:9-22, a description of any final board disciplinary action taken within the most recent ten years is included on the New Jersey Health Care Profile maintained by the Division of Consumer Affairs for all licensed physicians. Links to copies of Orders described thereon are also available on the Profile website. See http://www.njdoctorlist.com.

Copies of disciplinary Orders entered by the Board are additionally posted and available for inspection or download on the Board of Medical Examiners' website.
See http://www.njconsumeraffairs.gov/bme.

Pursuant to federal law, the Board is required to report to the National Practitioner Data Bank (the "NPDB") certain adverse licensure actions taken against licensees related to professional competence or conduct, generally including the revocation or suspension of a license; reprimand; censure; and/or probation. Additionally, any negative action or finding by the Board that, under New Jersey law, is publicly available information is reportable to the NPDB, to include, without limitation, limitations on scope of practice and final adverse actions that occur in conjunction with settlements in which no finding of liability has been made. Additional information regarding the specific actions which the Board is required to report to the National Practitioner Data Bank can be found in the NPDB Guidebook issued by the U.S. Department of Health and Human Services in April 2015. See http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf.

Pursuant to N.J.S.A. 45:9-19.13, in any case in which the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, the Board is required to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders entered by the Board is provided to the Federation on a monthly basis.

From time to time, the Press Office of the Division of Consumer Affairs may issue press releases including information regarding public actions taken by the Board.

Nothing herein is intended in any way to limit the Board, the Division of Consumer Affairs or the Attorney General from disclosing any public document.