STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

August 27, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Leslie Schachar, M.D.
1925 N. Grand
Gainesville, Texas 76240

Leslie Schachar, M.D.
Box 833
Gainesville, Texas 76241

RE: In the Matter of Leslie Schachar, M.D.

Effective Date: 09/03/96

Dear Mr. Sheehan and Dr. Schachar:

Enclosed please find the Determination and Order (No.96-108) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

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

COPY

IN THE MATTER

OF

LESLIE SCHACHAR, M.D.

Administrative Review from a Determination by a Hearing Committee on Professional Medical Conduct

ADMINISTRATIVE REVIEW BOARD DETERMINATION ARB NO. 96-108

The Respondent **DR. LESLIE SCHACHAR** (Respondent) moves pursuant to Public Health Law (Pub.H.L.) §230-c(4)(a) (McKinney's Supp. 1996), requesting that the Administrative Review Board for Professional Medical Conduct overturn the determination by a Hearing Committee on Professional Medical Conduct (Committee) that revoked the Respondent's license to practice medicine in New York State. Board Members **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** have reviewed this case, with Administrative Law Judge **JAMES F. HORAN** serving as the Board's Administrative Officer. The Board sustains the Committee's Determination. We discuss our Determination below, after summarizing the Committee's Determination, the issues for review and the Board's review authority.

The Respondent submitted a brief on the Respondent's own behalf in this proceeding.

TERRENCE SHEEHAN, ESQ. represented the Office of Professional Medical Conduct (Petitioner).

COMMITTEE DETERMINATION ON THE CHARGES

PUB.H.L. §230(7) authorizes three member Committees from the State Board for Professional Medical Conduct (BPMC) to conduct disciplinary proceedings to determine whether physicians have committed professional misconduct, by violating N.Y. Education Law (Educ. L.) §6530. The Petitioner filed charges with BPMC alleging that the Respondent had violated Educ. L. §6530(9)(d)

because a duly authorized disciplinary agency from another state had found the Respondent guilty for conduct, which if committed in New York, would constitute professional misconduct in New York. The Petitioner charged that the Respondent executed an Agreed Order with the Texas State Board of Medical Examiners (Texas Board) in which the Respondent admitted to certain conduct. The Petitioner alleges that the Respondent's Texas conduct constitutes misconduct under the following categories, if committed in New York:

- practicing medicine with negligence on more than one occasion, in violation of Educ. L. §6530(3);
- practicing with gross negligence, in violation of Educ. L. §6530(4);
- performing professional services which have not been duly authorized by the patient, in violation of Educ. L. §6530(26); and
- failing to maintain for each patient a record which accurately reflects the patient's evaluation and treatment, in violation of Educ. L. §6530(32).

The Petitioner brought the case as an expedited proceeding under Pub.H.L. §230(10)(p), for a Hearing Committee to determine the nature and severity for the penalty to be imposed for the conduct, Matter of Siddiqui, Index No. 73383 (Third Dept. June 6, 1996).

Three BPMC Members, **PETER D. KUEMMEL, RPA (Chair), GERALD S. WEINBERGER, M.D.** and **PASCAL J. IMPERATO, M.D.** served as the Committee in this case, with Administrative Law Judge **MARC P. ZYLBERBERG** serving as the Committee's Administrative Officer. The Committee rendered a Determination on May 2, 1996, in which they found that the Texas Board issued an Agreed Order on June 28, 1995 suspending the Respondent's Texas medical license, staying the suspension and placing the Respondent on five years probation. The Agreed Order contained findings that the Committee incorporated into their Determination. The Agreed Order included findings that the Respondent:

- failed to provide sufficient evidence that he adequately documented the care and treatment of various patients;
- failed to provide sufficient evidence to show that he obtained adequate preoperative evaluations for various surgical patients prior to performing surgery; and
- failed to provide sufficient evidence that the vitrectomy with sceral tuck (VST) procedure which the Respondent performs is therapeutic and within the standard of care for macular degeneration disease.

The provisions for the Respondent's Texas probation included the requirements that the Respondent:

- cease performing VST procedures except under protocols submitted and approved by an institutional review board and after obtaining informed patient consent;
- obtain informed consent in all patient surgeries;
- obtain required Texas licensure for using the Respondent's mobile surgical unit;
- obtain and provide appropriate pre-operative medical clinical evaluation on all surgical patients and laboratory tests as the standard of care requires;
- obtain and document all appropriate ocular examination data prior to any surgical procedure, and as a minimum, obtain an appropriate work-up prior to cataract and vitrectomy surgery; and
- maintain adequate medical records on all patient visits, consultations, surgeries performed, drugs provided and treatment rendered.

The Committee concluded that the Respondent's conduct in Texas, if committed in New York, would constitute negligence on more than one occasion, performing professional services without patient authorization and failing to maintain adequate records. The Committee voted to revoke the Respondent's license to practice in New York. The Committee found the Respondent's misconduct to be very serious. The Committee also found that the letter that the Respondent submitted to the Committee to be disturbing and to demonstrate that the Respondent lacked insight that he had been providing care at an unacceptable level. The Committee considered the Respondent's failure to appear at the Hearing and offer evidence in mitigation when the Committee imposed their sanction.

REVIEW HISTORY AND ISSUES

The Respondent filed a Notice requesting a review in this case, which the Board received on May 13, 1996. The Notice stayed the Committee penalty automatically, pending the Board's final Determination on the review (Pub.H.L. §230-c (4)(a)). The Respondent submitted a letter brief raising his issues on review, which the Board received on May 28, 1996. The Respondent failed to provide a copy of that letter to the Petitioner. After receiving a copy of the Respondent's brief from the Board's Administrative Officer, the Petitioner filed a reply on June 24, 1996.

The Respondent contends that the Committee's penalty was too harsh. The Respondent asked the Board to consider the following points:

1- No other state where the Respondent maintains a license, not Texas, Maine nor Florida, has revoked the Respondent's license.

2- The Respondent did not appear at the hearing due to illness. He asserts that someone told him the appearance was optional.

3- The Respondent was not performing experimental surgery. He asserts that the Texas Board was concerned that surgery in a mobile eye unit was illegal. The Respondent asserts that experimental surgery means surgery performed on animals.

4- The Respondent only signed the Agreed Order because he was depressed. He asserts he never caused patient harm.

The Petitioner's reply contends that the Respondent has offered no valid grounds to disturb the Committee's Determination. The Petitioner argues that:

- New York is not bound by the penalty which other states imposed for the Respondent's misconduct; and

- the Respondent's statement, that experimental surgery only applies to procedures on animals, is either disingenuous or it indicates that the Respondent doesn't understand the Texas Board's Order.

THE BOARD'S AUTHORITY

Pub.H.L. §230(10)(i), §230-c(1) and §230-c(4)(b) authorize the Board to review determinations by hearing committees for professional medical conduct and to decide:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Pub.H.L. §230-c(4)(b) permits the Board to remand a case to the Committee for further consideration. Pub.H.L. §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

The Board has the authority to substitute our judgement for that of the Hearing Committee, in deciding upon a penalty Matter of Bogdan 195 AD 2d 86, 606 NYS 2d 381 (Third Dept. 1993), in determining guilt on the charges, Matter of Spartalis 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994), and in deciding credibility issues, Matter of Minielly __AD 2d__, 634 NYS 2d 856, 1995 N.Y. App. Div. LEXIS 12692 (Third Dept. 1995).

THE BOARD'S DETERMINATION

The Board has reviewed the hearing record, the Committee's Determination and the parties' submissions. We sustain the Committee's Determination. The Board sustains the Hearing Committee's Determination that the Respondent conducted himself in Texas in a manner which would constitute negligence on more than one occasion, performing professional services without patient authorization and failing to maintain adequate records, if committed in New York. The Board votes 5-0 to sustain the Committee's Determination revoking the Respondent's license to practice in New York. The Board finds no merit in the Respondent's arguments challenging the Committee findings on the charges and their determination on the penalty.

The Respondent argued that Texas commenced the action against the Respondent because the Texas Board felt incorrectly that performing eye surgery in mobile units was illegal and that the Texas Health Department had found subsequently that such surgery was legal. The evidence before the Committee, however, demonstrated clearly that the Texas charges and findings arose from more than just the Texas Board's concern over the surgery location. The Texas Agreed Order contained findings that the Respondent failed to:

- document adequately patient care and treatment;
- obtain adequate patient evaluations before surgery; and
- demonstrate that he performed a procedure within the standard of care for macular degeneration disease.

In addition to these findings, the Texas Probation required, in part, that the Respondent:

- cease performing the VTS procedure except under protocols submitted to and approved by an institutional review board;
- obtain patient consent for surgery;
- obtain appropriate pre-operative evaluations and laboratory tests, under the required care standards, for all surgical patients; and
- maintain adequate patient medical records.

The findings and probation terms demonstrate that the Respondent failed to perform or obtain proper patient evaluations or tests, failed to obtain informed surgical consent, practiced medicine below accepted standards and maintained inadequate records. The evidence supports the Committee Determination that the Respondent's Texas conduct would constitute:

- practicing medicine with negligence on more than one occasion, in violation of Educ. L. §6530(3);
- performing professional services unauthorized by the patient, in violation of Educ. L. §6530(26); and
- failing to maintain adequate patient records, in violation of Educ. L. §6530(32).

The Respondent also challenged the Committee's Determination by arguing that he signed the Texas Agreed Order only because he was severely depressed. Neither the Board nor the Committee can reopen or invalidate the Texas Order. The document which the Respondent signed in Texas continues to bind him in this State.

The Board concludes that the Committee acted appropriately and acted consistently with their findings and conclusions when the Committee revoked the Respondent's New York medical license. The decisions by Texas, Maine and Oklahoma, to allow the Respondent to retain his license, do not bar New York from revoking the Respondent's license if we feel that sanction is necessary to protect our citizens.

The Respondent's medical practice in Texas fell below acceptable standards. The Respondent's letter to the Committee and his letter brief to the Review Board demonstrate that the Respondent lacks insight into his deficiencies as a physician. A physician lacking insight into his practice deficiencies will be unable to correct them and will remain a threat to continue providing sub-standard patient care. The Respondent also failed to obtain patient consent prior to surgery. Such

conduct constitutes a violation of a patient's right and demonstrates a breach of the essential trust that must be present between a patient and physician. These actions by the Respondent lead the Board to conclude that the Respondent is unfit to practice medicine in New York. The Board agrees with the Hearing Committee that revocation is the appropriate penalty in this case.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Board **SUSTAINS** the Hearing Committee's Determination finding the Respondent guilty of professional misconduct.

2. The Board **SUSTAINS** the Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF LESLIE SCHACHAR, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schachar.

DATED: Schenectady, New York
July 21, **1996**

ROBERT M. BRIBER

IN THE MATTER OF LESLIE SCHACHAR, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schachar.

DATED: Delmar, New York

August 19, **1996**

SUMNER SHAPIRO

IN THE MATTER OF LESLIE SCHACHAR, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schachar.

DATED: Brooklyn, New York

8/22, **1996**

WINSTON S. PRICE, M.D.

IN THE MATTER OF LESLIE SCHACHAR, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schachar.

DATED: Roslyn, New York
Aug 17, **1996**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF LESLIE SCHACHAR, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr Schachar.

DATED: Syracuse, New York
19 Aug, **1996**

William A Stewart

WILLIAM A. STEWART, M.D.