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

September 28, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Frederick Zimmer, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Lawrence J. Vilardo, Esq.
1020 Liberty Building
Buffalo, New York 14202

Joachim Amato, M.D.
6546 East Quaker Street
Orchard Park, New York 14127

RE: In the Matter of Joachim Amato, M.D.

Effective Date: 12/01/95

Dear Mr. Zimmer, Mr. Vilardo and Dr. Amato:

Enclosed please find the Determination and Order (No.95-129) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

IN THE MATTER

OF

JOACHIM AMATO, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 95-129

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on September 8, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) June 22, 1995 Determination finding Dr. Joachim Amato (Respondent) guilty of professional misconduct. Both the Respondent and the Office of Professional Medical Conduct (Petitioner) requested the Review through Notices which the Board received on July 3, 1995 and July 5, 1995. James F. Horan served as the Administrative Officer to the Review Board. Frederick Zimmer, Esq. filed a brief for the Petitioner, which the Review Board received on August 9, 1995. Lawrence J. Vilardo, Esq. filed a brief for the Respondent, which the Review Board received on August 9, 1995. Both parties submitted reply briefs, which the Board received on August 18, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- 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.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an obstetrician, with practicing medicine with negligence on more than one occasion, incompetence on more than one occasion, gross negligence and gross incompetence. The charges involved the care which the Respondent provided at five births, for patients to whom the record refers as Patients A through E.

The Hearing Committee sustained all the factual allegations in the Statement of Charges (DOH Exhibit 1), but concluded that these findings supported a determination that the Respondent was guilty of negligence on more than one occasion and incompetence on more than one occasion. The Committee determined that the Respondent was not guilty of gross negligence or gross incompetence.

The Committee found that in treating Patient A, after Patient A had delivered the first of a set of twins, the Respondent failed to recognize that the second twin's position was uncertain and failed to ascertain whether a vacuum assisted delivery would be appropriate. The Committee also found that the Respondent failed to monitor the second twin adequately and that the twin's respiratory difficulties and the indication of acidosis indicated that the twin suffered a diminished oxygen capacity as a result of inadequate monitoring. The Committee also found that the Respondent committed a clear case of misconduct by applying a vacuum extractor to deliver the second twin, without ascertaining adequately the twin's position to determine whether the twin was in the proper position for such a delivery. The Committee found that a vacuum extractor should only be applied to a fetal head and that application in an inappropriate position could cause traumatic injuries to a fetus. The Committee found that the Respondent had applied the vacuum extractor to the twin's left scapula and that the twin was born with a diminished spinal tone, poor cry and extensive bruising.

Addressing the treatment for Patient B, the Committee found that the Respondent ruptured the Patient's membranes inappropriately in the presence of an unengaged fetal head. The Committee concluded that an artificial rupture was appropriate only in an emergency situation with a set up for a Cesarean Section present. In this case, the Committee found that the Respondent did not have Cesarean set up when he ruptured the Patient's membranes and did not have a set up available until after five hours later. The Committee also concluded that the Respondent had augmented Patient B's labor inappropriately by giving the Patient Pitocin three hours after the Patient's membranes had been ruptured and after three hours trial of labor. The Committee also found that the Respondent committed a significant deviation from accepted standards of care by applying traction with forceps which were not locked and in the presence of conditions that would make a forceps delivery difficult. Patient B's baby was born with severe facial bruising, a small skull fracture and a slight droop on the left side of her mouth.

In assessing the treatment for Patients C, D and E, the Committee found that the Respondent was guilty of misconduct for failing to examine the three patients during long arrests or failure to progress in labor, that the Respondent had inappropriately left the hospital while the Patients were receiving Pitocin during long second stage labors and that the Respondent failed to address potential problems or determine causes for the prolonged labor or arrests of labor. The Committee found that in the cases of Patients C and E, which involved voluntary inductions of labor, there was no indication in the Patients' records to show an evaluation for the Patients' pelvic capacity or fetal size. The Committee concluded that these omissions deviated from accepted medical standards. The Committee also found discrepancies in both Patients' records concerning the reasons for the inductions. The Committee also found that during Patient E's prolonged labor, the Respondent, while away from the hospital, ordered that the epidural anesthetic for the Patient be topped off. The Committee found that both the anesthesiologist and the nurse advised the Respondent against topping off the epidural due to concerns over the Patient's blood pressure.

In reaching their findings and conclusions, the Committee relied on testimony by the Petitioner's expert witness Dr. Vinceguerra, whose testimony the Committee offered greater weight than the testimony by the Respondent's expert Dr. Howard. The Committee concluded that, although Dr. Howard was well-qualified and extremely knowledgeable, his testimony minimized the significance of the Respondent's actions and placed the Respondent in an unreasonably favorable light. In making their findings on the forceps delivery in Patient B's case, the Committee noted that they relied on testimony by the attending Anesthesiologist Dr. Bardick and the consulting Senior Obstetrician Dr. Gullo. Both those physicians testified that the Respondent applied traction in attempting a forceps delivery, while Dr. Gullo did not apply traction. The Hearing Committee also stated that they had concerns that some of the Respondent's testimony indicated a lack of familiarity with basic concepts of medicine, such as the Respondent's statement that a cord prolapse is not necessarily an emergency[1].

The Committee voted to suspend the Respondent's license to practice medicine until he completes an evaluation of his skills and a course of retraining at the Physician Prescribed Educational Program (PPEP) at Syracuse or an equivalent program. The Committee provided further that if the PPEP Evaluation indicated that the Respondent was not a candidate for re-training or was not suitable for training as the Committee directed, then the Respondent should enroll in and complete a program of re-training in the area of Obstetrics and Gynecology to be equivalent to a six month residency program, which would be subject to the approval by the Director of the Office of Professional Medical Conduct.

In reaching their Penalty Determination, the Committee considered that the Respondent's privileges at Milliard Fillmore Hospital were restricted in 1990 and 1993. The Committee stated that they felt that two restrictions within a few years should have alerted the facility to the need for greater oversight on the Respondent's practice and that the manner in which restrictions were removed from the Respondent's practice in 1993 was insufficient in addressing the Respondent's practice as a

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[1]An umbilical cord prolapse results from pressure on the cord that decreases blood flow to the baby, and requires an immediate Caesarean Section to avoid the effects of diminished blood flow. (H.C. FOF. 26, p. 9)

physician. The Committee concluded that a suspension, rather than a revocation, would be appropriate in the Respondent's case. The Committee found that the Respondent's testimony demonstrates a motivation to improve his skills that led the Committee to believe that the Respondent had a willingness to correct certain deficiencies and would be receptive to further education.

REQUESTS FOR REVIEW

RESPONDENT: The Respondent has asked that the Review Board set aside the Committee's Determination that the Respondent was guilty of professional misconduct because the finding was inappropriate. In the alternative, the Respondent asks that the Review Board impose a less severe penalty against the Respondent.

The Respondent contends that there were several legal errors that created a bias against the Respondent and asks that the Review Board consider that bias in reviewing the Committee's Determination. The Respondent contends that the Committee's Administrative Officer improperly curtailed the Respondent's cross-examination on the Petitioner's witness Dr. Vinceguerra; that Dr. Vinceguerra volunteered testimony improperly, that the Administrative Officer recused a Hearing Committee member without proper justification and the initial hearing day continued with only two panel members; that the Committee learned more about the suspension of the Respondent's hospital privileges than they needed to know and that certain additional information was extraneous and prejudicial; and, that certain other rulings by the Administrative Officer worked improperly to the Respondent's disadvantage. The Respondent also argues that a physician should not be guilty of professional misconduct merely because the physician deviated from accepted standards of medicine on two occasions. The Respondent argues that professional misconduct should require proof of repeated, similar acts of negligence or incompetence.

The Respondent argues that there was no evidence of repeated, similar acts in which the Respondent deviated from accepted standards. The Respondent argues that Patient B's case should not be part of the proceeding because that was subject to an earlier Health Department investigation and because the Respondent no longer practices the type of forceps delivery that was involved in that

case. In the cases of Patients C through E, the Respondent argues that he was not guilty of repeated negligence and incompetence in those cases because the Milliard Hospital "approved" the Respondent's treatment in those cases. The Respondent's brief contends that in all five cases, the Respondent was trying to avoid subjecting his pregnant patients to Cesarean Section unless the surgery was necessary. The Respondent also questions the Committee's decision to credit the testimony by Dr. Vinceguerra, the Petitioner's expert. The Respondent also challenges all the Committee findings of fact and conclusions concerning negligence and incompetence. Finally, the Respondent notes that he had to defend the exact medical decisions and his patient management course in proceedings involving his privileges at Milliard Fillmore Hospital and that the Respondent regained full privileges at the Hospital. The Respondent argues that it is inherently unfair to force him to defend those issues again in this proceeding.

PETITIONER: The Petitioner has asked that the Review Board overrule the Hearing Committee's Determination on the Specification alleging gross negligence and gross incompetence, and asks that the Review Board find the Respondent guilty of gross negligence and gross incompetence in treating Patients A through E. The Petitioner asks further that the Board overrule the Hearing Committee's Penalty and revoke the Respondent's license to practice medicine in New York State. The Petitioner contends that the Respondent is not a candidate for retraining and that the Committee's penalty is not adequate to ensure that the Respondent will practice acceptable medicine. The Petitioner urges the Board to revoke the Respondent's license to practice in New York State because the Respondent's lack of judgement in providing care to Patients A through E can not be corrected through retraining. The Petitioner argues that revocation is necessary to protect against future misconduct that would inevitably occur if the Respondent continues to practice.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes 5-0 to sustain the Hearing Committee's Determination finding the Respondent guilty of negligence on more than one occasion and incompetence on more than one occasion. The Hearing Committee's Determination is consistent with the Committee's findings and conclusions and is supported by the record in the cases and by the testimony which the Hearing Committee found to be credible. The Review Board defers to the judgement of the Hearing Committee in determining which testimony was credible. We further sustain the Committee's Determination that the Respondent was not guilty of gross negligence or gross incompetence in these cases.

We note at the outset that the Respondent's claims alleging errors in the Respondent's scope of cross-examination, the recusal of a Committee member and questioning of witnesses are legal matters which are beyond our authority and which the Respondent should raise with the courts. As to the Respondent's complaint concerning completing the first hearing with only two Committee members, Public Health Law §230(10)(f) allows a hearing to proceed in face of a Committee member's incapacity to continue, so long as the replacement Committee member affirms in writing that he or she has read and considered evidence and transcripts of prior days. The fact that one member missed hearing a portion of the testimony does not equate to a due process violation, Matter of Nenno, 210 AD2d 827, 620 NYS 2d 589, 1994 App. Div. LEXIS 13255 (Third Dept. 1994). As to the standard for misconduct, the Board rejects the Respondent's argument that a physician is not guilty of misconduct merely for failing to follow accepted medical procedures on two occasions. Education Law §§6530(2) and (4) define professional misconduct to include negligence on more than one occasion and incompetence on one occasion. The law does not require a showing of repeated, similar acts of negligence or incompetence, that the Respondent argues must be present to prove misconduct. Although the law does not require proof of repeated, similar acts of negligence or incompetence to prove misconduct, the Board finds that the Respondent's conduct in the treatment

of Patients A through E does demonstrate repeated instances of negligence and incompetence and that some of the repeated acts are similar in nature, especially those arising from the care provided to Patients C, D and E.

By a vote of 5-0, the Review Board overturns the Hearing Committee's Penalty, which placed the Respondent on suspension during evaluation and retraining. The Review Board votes unanimously to revoke the Respondent's license to practice medicine in New York State. The Committee stated in their Determination that they did not believe revocation was necessary in this case, because a suspension and retraining would protect the public and because the Respondent was a candidate for retraining. The Review Board finds nothing in the record to support the Committee's conclusion that the Respondent is a candidate for retraining. The Review Board finds that the Respondent's practice deficiencies, as demonstrated in his treatment for Patients A through E, pose a danger to his future patients and in the absence of any means to correct those deficiencies, revocation is the only appropriate penalty.

The Respondent placed Patients A through E and their babies at risk, and caused significant harm to Patient A's second twin and to Patients B's baby. The Respondent failed to determine the position of Patient A's second twin before applying a vacuum extractor. The Respondent ruptured Patient B's membranes without an engaged fetal head, and without a Caesarean Section set-up available at the time of the rupture or for five hours thereafter. The Respondent ordered the administration of Pitocin to Patient B three hours after rupturing the membranes. The Committee found it inappropriate to augment labor with Pitocin after the Patient had already endured a three hour trial of labor. In Patient B's case, the Respondent then attempted inappropriately to apply traction with forceps which were not properly locked or articulated. The Respondent failed to document evaluations or findings that would show a basis for voluntary inductions of labor in Patients C and E. The Hearing Committee also noted discrepancies in Patients C and E's medical records concerning the reason for inducing labor. In the cases of Patient C, D and E, the Respondent left the hospital for long periods during the second stage of labor. The Respondent left for those long periods even though

he had ordered Pitocin to augment the labor. The Respondent failed to examine those patients during prolonged second stages of labor while the Patients received Pitocin, was not present to address potential problems and failed to investigate in a timely manner, the cause of the protracted second stage labors.

The Review Board finds that the Respondent's treatment and actions in these five cases demonstrate an absence of the requisite skill, knowledge and judgement to practice safely. The Review Board finds further that the Respondent demonstrated a lack of character by failing to remain in the hospital to care for Patients C through E during their second stage and through the discrepancies in the Patient records concerning the reasons for inducing labor in the cases of Patients C and E. Neither judgement nor character can be improved by re-education or remediation. Although knowledge and skills can improve through re-training, the Board finds nothing in the record to demonstrate that the Respondent possesses the ability, insight and motivation necessary to benefit from retraining. We find the Respondent's repeated instances of similar misconduct to demonstrate that the Respondent lacks insight into his deficiencies. The repeated instances of similar misconduct included the Respondent's errors concerning Pitocin in the cases of Patients B through E, and his failure to be present to handle potential problems or to explore the causes for prolonged arrested labor in the cases of Patient C through E. There is no indication that Respondent has a motivation to correct his problems. Between 1990 and 1993, Milliard Fillmore Hospital restricted the Respondent's privileges twice, yet the Respondent demonstrated the same lack of judgement, skill and knowledge following these restrictions. The deliveries of Patients C and E followed those restriction periods. We also see no evidence that the Respondent can learn from his mistakes. Less than three months after his negligent and incompetent care during Patient C's delivery, the Respondent committed stunningly similar deviations from acceptable care and demonstrated the same lack of skill and knowledge during Patient E's delivery. Finally, we find no mitigating factor due to the Respondent's youth. The Respondent completed his formal medical training only a few years before his acts of misconduct in treating Patient A.

The Review Board considered a less severe sanction than revocation. We considered, but rejected, a limitation to prohibit the Respondent from practicing obstetrics. The Board rejected such a limitation because we found that the Respondent's demonstrated lack of judgement, skill or knowledge indicates that the Respondent lacks the general competence to practice medicine. Diagnosis, good judgement and management of medication is common to all medicine. The Respondent demonstrated deficiencies in diagnosis in failing to ascertain the position of Patient A's second twin, in failing to document indications for inducing labor in Patients C and E, and in failing to examine the reasons for prolonged labor in Patients C through E. The Respondent committed errors in ordering or managing Pitocin for Patients B through E. The Respondent ordered Pitocin inappropriately for Patient B, after the patient had already had a three hour trial of labor. In the cases of Patient C through E, the Respondent ordered Pitocin, but then left the hospital and failed to monitor the Patients. The Respondent showed a lack of good judgement in all these cases, but that lack of judgement was most evident in applying a vacuum extractor to Patient A without ascertaining adequately the position of Patient A's second twin and in trying to apply traction with unlocked forceps in delivering Patient B's baby.

In view of the Respondent's repeated acts of negligence and incompetence, the danger he would pose to future patients and in the absence of any indication that the Respondent could improve his practice through retraining, the Review Board finds that revocation of the Respondent's license is the only appropriate penalty in this case.

ORDER

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

1. The Review Board **SUSTAINS** the Hearing Committee on Professional Medical Conduct's June 22, 1995 Determination finding Dr. Joachim Amato guilty of professional medical conduct.

2. The Review Board **OVERTURNS** the Hearing Committee's Penalty , which suspended the Respondent's license during a period of retraining.

3. The Review Board **REVOKES** 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 JOACHIM AMATO, 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. Amato.

DATED: Albany, New York
Sept 22, 1995

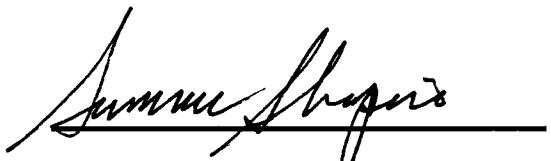
ROBERT M. BRIBER

IN THE MATTER OF JOACHIM AMATO, 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. Amato.

DATED: Delmar, New York

Sept. 21, 1995



SUMNER SHAPIRO

IN THE MATTER OF JOACHIM AMATO, 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. Amato.

DATED: Roslyn, New York
September 21, 1995

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF JOACHIM AMATO, 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. Amato.

DATED: Syracuse, New York
19 Sept , 1995

William A Stewart

WILLIAM A. STEWART, M.D.