STATE OF NEW YORK
DEPARTMENT OF HEALTH

Office of Public 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

June 22, 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.

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

Enclosed please find the Determination and Order (No. 95-129) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
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.

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

JOACHIM AMATO, M.D.

DETERMINATION

AND

ORDER

BMC-95-129

A Notice of Hearing and Statement of Charges, each dated October 7, 1994, were served upon the Respondent **JOACHIM AMATO, M.D.** **LEMUEL A ROGERS, JR., M.D.,** Chairperson, **JOHN P. FRAZER, M.D.** and **IRVING S. CAPLAN,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10(e) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges: October 7, 1994

Prehearing Conference: November 9, 1994

Dates of Hearings: November 17, 1994
December 8, 1994
December 9, 1994
January 4, 1995
February 1, 1995
February 2, 1995
February 28, 1995

Department of Health appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Frederick Zimmer, Esq. Associate Counsel
Respondent Appeared By:	Lawrence J. Vilardo, Esq. 1020 Liberty Building Buffalo, New York 14202
Witnesses for the Department of Health:	John Choate, M.D. Nancy Nielson, M.D. James Burdick, M.D. Thomas Gullo, M.D. Timothy J. Vinciguerra, M.D. Ronald J. Foote, M.D.
Witnesses for the Respondent:	Joachim Amato (Respondent) James T. Howard, Jr., M.D. Thomas C. Small, M.D. Marvin Pleskow, M.D.

AMENDMENTS TO THE STATEMENT OF CHARGES

The parties stipulated on November 17, 1994 to two (2) amendments to the Statement of Charges as follows:

1. **Factual Allegation Paragraph B.3.-DELETED.**
2. **Factual Allegation Paragraph B.4.-DELETE the word "THE".**

A copy of the Statement of Charges is attached hereto as Appendix I and is made a part of this Determination and Order.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T.= Transcript

GENERAL FINDINGS

The Respondent was authorized to practice medicine in New York State on March 11, 1983 by the issuance of license number 153319 by the New York State Education Department. The Respondent was registered with the New York State Education Department to practice medicine through the period ending December 31, 1994. (Ex. 3)

FINDINGS OF FACT RELATED TO PATIENT A

1. Patient A was admitted to Millard Fillmore Hospital on June 3, 1993 in labor with a known twin gestation and a due date of June 26, 1993. (Ex. 4, pp. 25-7; T. 169)

2. Twin A, a female baby, was successfully delivered vaginally via a vacuum extractor at approximately 12:15 a.m. on June 4, 1993. (Ex. 4, p. 49; T. 169-70, 644)

3. Following the delivery of Twin A, acceptable standards of medical care required that Respondent assess Twin B's fetal status, its presentation and position. An assessment of fetal status would include an assessment of fetal heart rate and an evaluation of whether the baby is suffering from complications such as separation of the placenta or cord entanglement. (T. 171-2).

4. Following the delivery of Twin A, the fetal heart monitor belt loosened on Patient A and a continuous heart tracing could not be maintained on Twin B. During the period between the twin deliveries, a nurse would manually reposition the monitor at least every minute to listen for Twin B's heartbeat. Twin B's fetal heartbeat was recorded on fetal monitoring strips. Dr. Vinciguerra testified that such strips contained inadequate tracings in that there was no evidence of a consistent monitoring of Twin B's heart rate throughout this period of time. (Ex. 4; T. 177, 192, 453-6, 647-8)

5. Presentation and position can be assessed either through physical examination by palpation or via ultrasound scanning which images the position and presentation of the baby. Dr. Vinciguerra testified that an ultrasound is useful in situations where there is confusion as to what part is presenting or to assist in manipulating the fetus to a configuration which facilitates delivery. (T. 172)

6. Following spontaneous delivery of the first twin, Respondent attempted to identify the second twin's presentation solely by palpation and did not perform an ultrasound (T. 644, 646)

7. Respondent's examination indicated that Patient A's membranes were intact and bulging with the second twin in a high presentation. He identified the second twin as being in a breech presentation. (T. 644, 646)

8. Respondent noted in Patient A's medical record during the early stages of her labor that the baby was presenting as a breech. (Ex. 4, pp. 27-8)

9. The delivery of Twin B failed to progress as the baby did not descend to the lower pelvic level. Respondent thereupon applied traction via a vacuum extractor to the baby, but was unsuccessful in assisting with its' descent. (Ex. 4, pp. 56-7; T. 650-1)

10. A vacuum extractor, a suction cup like device, is applied to the fetal head for the purpose of applying traction to assist descent of the baby and facilitate delivery. Dr. Vinciguerra testified that a vacuum extractor should properly be applied to the fetal head and not to a

non-vertex presenting portion of a fetus and further stated that inappropriate application of a vacuum extractor can result in traumatic injuries to the fetus. (T. 125-6, 170, 178)

11. Dr. Choate testified that Respondent told him in an interview on or about June 8, 1994 that Respondent had not learned through his training or reading of relevant medical literature that proper obstetric management could include the application of a vacuum extractor to a portion of a fetus other than the head. (T. 71-2, 110-1)

12. When the fetus failed to descend adequately, Respondent reached into the uterine cavity and palpated what he determined as being a leg. Respondent brought the presenting part down to determine if he could bring Twin B out by the feet and established that the presenting part was a hand. At that point in time, Respondent recognized that the fetus was in a transverse lie rather than a breech presentation. (Ex. 4, p. 57; T. 651-2)

13. A transverse lie occurs when the baby lies crosswise across the pelvis and presents either a shoulder or back, or the front of the baby if the baby's back is up, instead of a body part that is able to transverse the pelvis. (T. 177)

14. Respondent had applied the vacuum extractor to Twin B's left scapula. (T. 654)

15. After identifying the second twin as being in a transverse lie presentation, Respondent proceeded to deliver the infant via a Cesarean section. (Ex. 4, p. 57; T. 652-3)

16. Twin B, a baby boy, was born with minimal to no respiratory effort and required intubation with bagging prior to having spontaneous respirations. Twin B was intubated upon transfer to the recovery room nursery. He was born with Apgar scores of 3, 5 and 8 indicating that he required assistance following delivery and resuscitation techniques to elevate his heart

and respiratory rates and to improve his oxygenation, and he was born with a cord ph of 6.94 and a base excess of minus 12 reflective of metabolic acidosis. (Ex. 4, p. 52; Twin B's Record pp. 2, 10; T. 180-184)

17. Twin B was also noted to have been born with diminished spinal tone, poor cry, extensive bruising of the left arm, shoulder/scapula and entire thoracic area. His hospital progress record indicated that his left arm was the presenting part vaginally. (Ex. 4, Twin B's record p. 10; T. 183-4)

FINDINGS OF FACT RELATED TO PATIENT B

18. Patient B was admitted to Millard Fillmore Hospital on April 3, 1990 at 7:45 a.m. in early labor with her first term pregnancy. (Ex. 5, p. 25; T. 193, 593)

19. At 7:50 a.m., Respondent performed a pelvic examination and found Patient B's cervix to be dilated to four (4) centimeters and 90% effaced. Respondent recorded the station as being high. (Ex. 5, pp.23, 25; T. 193-4)

20. At 12:30 p.m. Respondent recorded a progress note in which Patient B was reported as having contractions every three (3) minutes with strong fetal heart rates of 130-140 with a good pattern. The cervix was reported as dilated from six (6) to (7) centimeters, 90% effaced. The station was recorded as high with membranes bulging. (Ex. 5, p. 27; T. 196, 599-600)

21. At 3:45 p.m. Respondent recorded a progress note in which Patient B was reported to be having strong contractions every three (3) minutes. Her cervix was dilated from eight (8) to (9) centimeters and 90% effaced. The station continued to be reported as high. (Ex. 5, p. 27; T. 196-7, 600)

22. Respondent, at approximately 3:45 p.m., artificially ruptured patient B's membranes (Ex. 5, p. 27; T. 197, 600)

23. The purpose of artificially rupturing membranes is to release amniotic fluid from the gestational sac. This procedure may enhance labor and the descent of an engaged head down into the pelvis. (T. 198)

24. Following the artificial rupture of Patient B's membranes, the cervix was reported as being dilated from to five (5) to six (6) centimeters and the presenting part of the fetus was still unengaged. Respondent reported "probable cephalopelvic disproportion" but noted that he would continue labor at least two more hours. (Ex. 5, pp. 27-28; T. 197-8, 603-4)

25. Engagement of the head signifies clinically that the biparietal diameter or broadest part of the baby's head has passed through the inlet or opening of the pelvis. Engagement of the head has occurred when the lowermost or leading portion of the baby's head is at a level opposite the ischial spines in the female pelvis, referred to as zero station. An unengaged head indicates that the fetal head has not descended low enough to fill the pelvic inlet. (T. 75-6, 199, 457, 597-8)

26. Dr. Vinciguerra testified that a cervix dilated at eight (8) to nine (9) centimeters prior to artificial rupture of the membranes and five (5) to six (6) centimeters thereafter could enable

loops of umbilical cord to wash down in advance of the head in the flow of fluid released by the rupture. This in turn could create pressure to the cord from the fetal head which could decrease blood flow to the baby and create an emergency situation known as umbilical cord prolapse. An umbilical cord prolapse would require a Cesarean section to deliver the baby promptly to avoid the effects of the diminished blood flow. (T. 199-200, 218-9)

27. Dr. Vinciguerra testified that the artificial rupture of Patient B's membranes in the presence of an unengaged head did not meet acceptable standards of medical care. The artificial rupture of the membranes should only be performed in the presence of an unengaged head when delivering a stillborn fetus or in emergency situations in which the infant must be delivered quickly. A setup for Cesarean section should be present to deal with possible cord prolapse. (T. 199, 216-7, 457)

28. Respondent did not have a setup for Cesarean section at the time he artificially ruptured the patient's membranes and did not have such a set-up until 9:00 p.m. (T. 614-5, 780-1)

29. Cephalopelvic disproportion (CPD) occurs when the fetal head is too large for the mother's pelvic capacity. It can lead to protracted labor or the inability to deliver. The presence of an unengaged head in the course of labor is indicative of CPD. (T. 198-9, 217)

30. At 6:45 p.m., Patient B was reported as being dilated to 9 centimeters, 90% effaced with contractions every three (3) to four (4) minutes of moderate strength and good fetal heart tone. The baby's station was documented as minus one with molding present. Respondent augmented Patient B's labor with Pitocin because of contraction spacing and shortening in order to strengthen the natural contractions and ordered repeat Nubain, an anesthetic and relaxing agent. (Ex. 5, p. 28; T. 200, 606-7)

31. Molding is the softening and reshaping of the baby's head to conform to the shape of the pelvis to enable it to pass through. It occurs as a result of the forces of labor molding the baby's head as it is pushed through the birth canal. The plates of the infant's skull may override one another causing the shape of the infant's head to elongate. (T. 51, 605)

32. Dr. Vinciguerra testified that in circumstances in which the descent of a fetus is limited, a significant degree of molding is present, the fetal head is unengaged following a significant amount of labor and probable CPD is noted, the augmentation of labor would be contraindicated because it would attempt to force through a baby too large for the pelvis. (T. 200-201)

33. At approximately 8:40 p.m., Patient B was moved to a delivery room. A spinal anesthetic was started at 8:50 p.m. At approximately 8:55 p.m., Respondent began an attempt at a forceps delivery of Patient B's baby. (Ex. 5, pp. 40, 43; T. 88-9, 102-3)

34. Respondent recorded a progress note at 9:00 p.m. in which Patient B was reported as being fully dilated and pushing. The fetus was noted to be left occiput posterior and at a zero to plus one station. Respondent noted his plan to pursue a trial of forceps under a spinal and to perform a Cesarean section if the forceps failed. (Ex. 5, p 28; T. 201, 607)

35. Respondent first attempted to rotate the baby into a suitable position by applying Kjelland's forceps, but was unable to do so. He testified that he then applied Simpson's forceps, but could not successfully lock the handles. Respondent made several unsuccessful attempts to lock the handles, during which time he applied traction in an attempt to move the baby's head. Respondent applied traction with unlocked forceps on multiple attempts during the period of 8:55 to 9:10 p.m. (Ex. 5, pp. 40, 43, 45; T. 90-1, 617-8)

36. Traction is the pulling force applied with forceps to deliver the fetal head. Traction should not be applied until the application of the forceps is checked to ensure that they accurately accommodate certain fetal skull landmarks. Proper use of forceps entails appropriate articulation or locking of the forcep handles to determine accurate application of the forceps to the fetal head. Appropriate articulation involves the lock fitting together without any misplacement and without difficulty in moving the lock. In the absence of appropriate articulation, the forcep blades cannot be brought together correctly when applied to the fetal head. (T. 46, 147, 208-10, 466, 534-5)

37. At approximately 9:05 p.m., Dr. Gullo entered the delivery room and attempted to assist the Respondent. Dr. Gullo testified that he observed that Respondent had incorrectly applied forceps on the baby because the buttons on the forceps were not facing the head. Dr. Gullo attempted to apply both Kjelland and Tucker-McLean forceps but was unable to lock either set of forceps. He testified that he believed he could not successfully apply the forceps because the head was severely molded and elongated. (T. 92, 135-7)

38. Dr. Gullo did not apply traction while attempting to place the two sets of forceps. After his efforts proved unsuccessful, he recommended that Respondent perform a Cesarian section to deliver the baby. (T. 92-3, 137, 150, 620)

39. Patient B's baby, a girl, was delivered at approximately 9:26 p.m. by Cesarian section. She was determined to have sustained extensive molding, severe facial bruising and a small skull fracture. A slight droop of the left side of her mouth was also noted. (Ex. 5, p. 43; Baby's record pp. 45, 68; T. 212, 623)

40. Respondent documented in the operative report that the fetal presenting part was at approximately what appeared to be plus two station when he first attempted to apply forceps. He further noted a postoperative diagnosis of CPD. (Ex. 5, p. 45)

41. Dr. Vinciguerra testified that he believed that the cause of the baby's skull fracture and facial nerve damage was the inappropriate use of forceps from an unacceptably high station on a fetus that had cephalopelvic disproportion. (T. 213-214)

FINDINGS OF FACT RELATED TO PATIENT C

42. Patient C was admitted to Millard Fillmore Hospital at approximately 9:00 a.m. on December 22, 1993 for the elective induction of labor with a first term pregnancy and an expected date of confinement of December 21, 1993. She was 27 years old with a height of five feet seven inches and a weight of 265 pounds. (Ex. 6, pp. 27-9, 43, 57)

43. Respondent noted "N.L.", representing "normal limits", in describing the condition of Patient C's pelvis on her prenatal record. Respondent's office record for Patient C contained no additional evaluation of Patient C's pelvic capacity to deliver Baby C. (Ex. 6, p. 28, Ex. L; T. 412, 572-3)

44. Respondent's evaluation of Patient C upon admission noted an estimated fetal weight of seven (7) pounds, two (2) ounces, a fetal heart rate of 130 beats per minute and a cervical assessment showing 60% effacement, dilation of two (2)-three (3) centimeters and the baby as a vertex presentation at minus three (-3) station. (Ex. 6, p. 27)

45. There was no indication in Patient C's hospital record that Respondent assessed Patient C's pelvis or pelvic capacity upon her admission to Millard Fillmore Hospital or determined the actual fetal weight of her baby. (Ex. 6, p. 27; T. 224-225, 565-570, 572-3)

46. Dr. Vinciguerra testified that the accepted standard of medical care requires that a valid indication for the induction of labor be documented in a patient's obstetric record prior to beginning such induction and that indications for induction would include the assessment of fetal size and the relationship of that size to pelvic capacity. (T. 575-6)

47. Respondent documented the basis for the induction of labor as being for personal reasons; to enable her husband to be present during the delivery, and because the fetus was large for its gestational age. (Ex. 6, pp. 29, 62, 64)

48. Pitocin was started to induce Patient C's labor at approximately 10:30 a.m. (Ex. 6, pp. 43, 64; T. 696)

49. Respondent personally examined Patient C at approximately 12:30 p.m. and again at 4:45 p.m. An epidural was given to the patient at about 6:00 p.m. Respondent subsequently telephoned to inquire about the patient's status at 7:30 , 9:45 and 11:00 p.m. (Ex. 6, pp. 46, 51, 54; T. 697-9)

50. Patient C became fully dilated at about 9:00 p.m. (Ex. 6, pp. 51, 62, 64; T. 699)

51. At 11:55 p.m., Patient C was reported as being fully dilated, 100% effaced, at zero (0) to minus one (-1) station and pushing for approximately one (1) hour 15 minutes. Respondent was paged at home. (Ex. 6, p. 30; T. 700)

52. At 12:05 a.m., Respondent evaluated Patient C and found that she was very tired from pushing and that the baby's head remained high. His plan was noted to be to turn off the Pitocin, give Patient C Nubain, allow her to rest and then to resume pushing in a few hours as long as the baby's condition remained stable. (Ex. 6, p. 30; T. 701, 703-4)

53. Respondent returned home shortly after his 12:05 a.m. evaluation of the patient. (T. 826)

54. At approximately 1:10 a.m. on December 23, 1993, the patient was noted as being more relaxed and able to sleep. Patient C rested until approximately 5:30 a.m., when she was noted to have resumed pushing. (Ex. 6, p. 54; T. 704-6)

55. Respondent was notified of the patient's status at about 6:30 a.m. At approximately 7:10 a.m., Respondent was called and asked to come in immediately to assess Patient C. He returned to the hospital at approximately 7:20 a.m. in the morning at which time he re-examined the patient. (Ex. 6, pp. 47, 50; T. 706-7)

56. Although Respondent's plan, noted at 12:05 a.m., was to discontinue Pitocin and permit the patient to rest, Pitocin continued to be administered to Patient C until approximately 7:10 a.m. (Ex. 6, pp. 30, 48-9, 50, 52; T. 239-40, 826)

57. Respondent noted at 7:30 a.m. that Patient C's contractions were continuing every three (3)-four (4) minutes and were strong, her fetal heart rate was good, her cervix was fully dilated and pushing and that the baby was at a questionable left occiput posterior position at plus two (+2) to plus three (+3) station. Respondent consulted with a senior staff member who agreed that a vacuum extraction should be attempted. (Ex. 6, p. 31; T. 707)

58. At approximately 8:00 a.m., Respondent made eight unsuccessful attempts to deliver the baby by vacuum extraction. He noted at 8:35 a.m. that he planned to perform a Cesarian section for a prolonged second stage. (Ex. 6, pp. 31, 50, 67)

59. Patient C's baby was delivered by Cesarian section at 9:03 a.m. with a birthweight of seven (7) pounds, nine (9) ounces and a temperature of 101. (Ex. 6, p. 68)

FINDINGS OF FACT RELATED TO PATIENT D

60. Patient D was admitted to Millard Fillmore Hospital on November 2, 1993 at approximately 10:00 a.m. in early labor with her second child with a cervix dilated to four (4) centimeters, 80% effaced with the baby at minus one (-1) station. (Ex. 7, pp. 19, 21; T. 657)

61. At 10:00 a.m., Respondent noted that Patient D's cervix was dilated five (5)-six (6) centimeters and was 90% effaced with the baby at zero (0) station in a vertex presentation. (Ex. 7, p. 22; T. 658)

62. Respondent telephoned the hospital to determine Patient D's status at approximately 12:45 p.m. and 4:15 p.m. He next examined the patient at about 6:00 p.m. (Ex. 7, pp. 32, 35; T. 659-60)

63. At approximately 6:00 p.m., Respondent noted that Patient D's membranes were artificially ruptured resulting in clear fluid and that she was given an epidural. Patient D's cervix was recorded as being dilated seven (7)-eight (8) centimeters at that time, with 90% effacement and the baby at zero (0) station. (Ex. 7, p. 23; T. 660)

64. Respondent went home after the 6:00 p.m. examination of the patient. At approximately 7:45 p.m., he issued a telephone order directing that Pitocin be administered to augment Patient D's labor. (Ex. 7, p. 13; T. 259, 660)

65. Respondent was notified at about 10:30 p.m. that the patient had become fully dilated. (Ex. 7, p. 36; T. 661)

66. At 11:00 p.m., Patient D had failed to make progress from pushing and was noted to be "getting very tired". It was further noted that the patient "will stop pushing for a little while". At 11:30 p.m., Patient D resumed pushing. (Ex 7, p. 36; T. 661-2)

67. At approximately 1:00 a.m., Respondent was telephoned at home by a nurse on the labor floor who notified him that Patient D had made no progress despite two (2) hours of pushing, that the infant's vertex was at zero (0) station and that caput was forming. Nubain was ordered by the Respondent. (Ex. 7, p. 36; T. 662-5)

68. At 2:30 a.m., Patient D was noted as being "very tired". A resident on the labor wing was called to evaluate her and, after having had the patient's circumstances explained, determined that he would allow the patient to push until 3:00 a.m. and then would evaluate her. (Ex. 7, p. 39; T. 666)

69. Following his physical examination and evaluation of the patient, the resident called Respondent at about 3:10 a.m. and was told to discontinue Patient D's Pitocin and that Respondent would be into the hospital in one (1) hour. The patient's progress notes indicate that Respondent was aware that Patient D's amniotic fluid was yellow, variability was decreased, and variable decelerations were occurring with contractions. The resident advised the Respondent that Patient D's pushing efforts were not very effective. (Ex. 7, p. 39; T. 667)

70. Amniotic fluid is generally almost colorless. Yellowish or greenish coloration is indicative of various degrees of meconium or fetal bowel contents passing into the amniotic fluid. Diluted meconium may present a yellowish tint (T. 117, 266-7, 968, 990-1)

71. The resident noted at 3:15 a.m. that Patient D was uncomfortable and tired of pushing, that she had a temperature of 101.4, that the fetal heart rate was in the 140s with acceleration, that variable decelerations with contractions were occurring, the baby was at zero (0) station with moderate caput, that Patient D's second stage of labor had continued for four (4) hours with minimal progress, that Pitocin would be discontinued and that if no progress occurred soon, a Cesarean section would be proceeded with as per his discussions with Respondent. (Ex. 7, p. 24; T. 264-265, 672)

72. Respondent was telephoned at approximately 4:10 a.m. by the charge nurse, and was advised that Patient D's status was unchanged and that the fetal heart rate had decreased variability and variable decelerations. Respondent informed the charge nurse that he would come to the hospital soon to evaluate the patient. (Ex. 7, p. 39; T. 673-674)

73. Respondent returned to the hospital at about 4:30 a.m. and conducted a pelvic examination of Patient D. He then obtained a consultation with the in-house attending physician, who recommended attempting a delivery with a vacuum assist. (Ex. 7, p. 39; T. 674-5)

74. An infant male was delivered by vacuum assist at approximately 5:33 a.m. The baby was noted to have meconium staining, molding with caput formation of the head and a temperature of 100. (Ex. 7, p. 46; T. 269-270)

FINDINGS OF FACT RELATED TO PATIENT E

75. Patient E was admitted to Millard Fillmore Hospital on February 3, 1994 at approximately 6:30 a.m. for induction of labor for her first pregnancy. Her expected due date was January 27, 1994. (Ex. 8, pp. 5, 27, 29; T. 729)

76. Respondent noted "NL", representing "normal limits", in describing the condition of Patient E's pelvis on her prenatal record. His office records contained no additional evaluation of Patient E's pelvic capacity to deliver her baby and contained no indication that he evaluated the patient for CPD. (Ex. 8, p. 28; T. 838-839, 853, 857)

77. Dr. Vinciguerra testified that the preinduction evaluation of Patient E, as reflected on the obstetric admitting record, did not meet acceptable standards of medical care in that there was no documented evaluation of Patient E's estimated or true fetal weight, of the possibility of cephalopelvic disproportion or of Patient E's pelvic capacity and ability to deliver her baby vaginally. (Ex. 8, p. 27; T. 277-278)

78. Respondent documented in Patient E's medical record that the reason for her hospital admission for the induction of labor was that her intrauterine pregnancy was at 41 weeks and was "post-term". (Ex. 8, pp. 29, 33)

79. Respondent testified that he ordered the induction of the patient's labor because she was one (1) week overdue in her delivery and because he had determined that the fetus was bordering on becoming macrosomic, or unusually large. (T. 729-730)

80. Patient E's pelvis was examined following her admission. Her cervix was recorded as being closed and 70% effaced. The baby was noted to be at minus one (-1) station and to be a vertex presentation. (Ex. 8, p. 30; T. 275-276)

81. Dr. Vinciguerra testified that Patient E's cervix was unfavorable for induction in that the patient was not dilated and was only 70% effaced and the baby's head was not engaged based on the noted minus one (-1) station (T. 276-277)

82. Pitocin was started at approximately 7:50 a.m. to begin the induction of labor. (Ex. 8, p. 49; T. 278)

83. Respondent examined the patient at about 1:00 p.m. and noted contractions with moderate intensity every four (4) minutes, that the cervix was dilated two (2) centimeters and was thick and that the baby was at minus one (-1) station. At that time, Respondent artificially ruptured Patient E's membranes. (Ex. 8, p. 30; T. 731-732)

84. At approximately 9:30 p.m., Respondent examined Patient E and found her to be dilated to three (3)-four (4) centimeters, 90% effaced with the baby at minus one (-1) station and making slow progress. He recorded his plan as being to continue Pitocin and increase it every 30 minutes. (Ex 8, p. 31; T. 734)

85. Respondent left the hospital and went home after the 9:30 p.m. examination of the patient. (T. 839)

86. Patient E reached full dilatation at about 2:20 a.m. on February 4, 1994. (Ex. 8, p. 56; T. 734, 839)

87. Between 2:20 a.m. and about 3:30 a.m., the patient was noted to be continuing to push. At approximately 3:30 a.m. an attempt was made to briefly rest Patient E. At about 3:40 a.m. she was noted to be tired but pushing well. (Ex. 8, pp. 56, 61; T. 735)

88. At about 4:05 a.m., Respondent was apprised via telephone of Patient E's status. He ordered that her epidural be topped off and that she be rested. The nurse advised Respondent that she was leery of topping off the epidural because of concerns about Patient E's blood pressure. (Ex. 8, p. 61)

89. At 4:15 a.m., the anesthesiologist recommended that the epidural not be topped off because of concerns that Patient E's blood pressure would drop. (Ex. 8, p. 61; T. 736)

90. At 4:50 a.m., Patient E was noted to have resumed pushing with no progress. (Ex. 8, p. 61)

91. At about 5:30 a.m., Respondent was advised by telephone that Patient E had made no further progress. He ordered the Pitocin off and the administration of intravenous Nubain to rest Patient E. Respondent was made aware that the patient was very tired in appearance and was crying. (Ex. 8, p. 61; T. 736-737)

92. Patient E rested for about one (1) hour. At approximately 6:45 a.m. Respondent ordered the Pitocin to be restarted. (Ex. 8, p. 61; T. 737-738)

93. Respondent personally examined and evaluated the patient at about 7:10 a.m. The baby was noted to be at a plus one (+1) to plus two (+2) station and Respondent recorded that he was uncertain as to it's position. His plan was to have the patient resume pushing for at least one (1) more hour. At about 7:15 a.m., Respondent ordered an increase in Pitocin. (Ex. 8, pp. 32, 61; T. 739)

94. Respondent examined the patient again at about 9:15 a.m. and, at approximately 9:45 a.m., recorded the baby's position as being plus two (+2) to plus three (+3) and that he remained uncertain as to the baby's position. (Ex. 8, p. 32, 61; T. 740)

95. At approximately 9:35 a.m., Respondent consulted with a more senior physician who concurred with a diagnosis of arrested descent after a prolonged second stage of labor and with the need for a Cesarean section (Ex. 8, pp. 32, 61; T. 741)

96. Patient E was transferred to an operating room at approximately 10:25 a.m. and gave birth to an eight (8) pound, thirteen (13) ounce boy via Cesarean section at 10:45 a.m. (Ex. 8, pp. 61, 66-67; T. 741)

FINDINGS OF FACT RELATED TO RESPONDENT'S CLINICAL PRIVILEGES AT MILLARD FILLMORE HOSPITAL

97. Respondent's privileges at Millard Fillmore Hospital were restricted for approximately six (6) months after the delivery of Patient B's baby in April of 1990. Respondent was required to obtain consultation from a senior attending physician whenever he performed an operative delivery, i.e.-the use of forceps, vacuum extractor or performance of a Cesarean section. In addition, all of Respondent's medical records were to be reviewed for a period of six months prior to, and six (6) months subsequent to, the April, 1990 delivery of Patient B's baby. (T. 583-584)

98. Respondent's privileges were reinstated in approximately the Fall of 1990, and he retained full privileges at Millard Fillmore Hospital until June, 1993. (T. 584-585)

99. Respondent's privileges at Millard Fillmore Hospital were restricted in June, 1993, following his delivery of Patient A's twin babies. In a letter from the Clinical Chief of the Department of Gynecology and Obstetrics dated June 7, 1993, Respondent was advised that he would be required to obtain consultation for all complicated obstetric cases, including multiple gestations, breech or other malpresentations, and for vaginal operative deliveries except for simple outlet vacuum extractions, and for any medical complications. (Ex. Q; T. 585, 756)

100. A subsequent letter from the Clinical Chief, dated August 12, 1993, specified that the period of Respondent's restriction of privileges would be for six (6) months subsequent to the June, 1993 notification to Respondent of such restriction. (Ex. P)

101. By a letter dated December 21, 1993, the Clinical Chief advised the Respondent that no further deviations from the standard of care had been found during the six (6) month period and that the previous restrictions on Respondent's privileges were removed. (Ex. H; T. 586)

102. Respondent's privileges were summarily suspended by Millard Fillmore Hospital in February, 1994. (T. 588)

103. A hearing regarding the suspension of Respondent's privileges was held before an ad hoc committee of the hospital. The committee consisted of seven (7) physicians, none of whom were from the Obstetrics and Gynecology department. The hearing was conducted during the period of June through August, 1994. (T. 588-589)

104. In a report dated September 13, 1994, the ad hoc committee determined that the hospital's medical staff had failed to prove by a preponderance of the evidence that the summary suspension of Respondent's privileges was warranted and recommended that the privileges be restored. (Ex. I)

105. By a letter dated October 4, 1994, Respondent was notified by the President and Chief Executive Officer of Millard Fillmore Hospital that the Board of Directors had approved the recommendation of the ad hoc committee that his clinical privileges be restored, subject to certain conditions. (Ex. 12)

106. At the time of the close of the record of this proceeding, Respondent did not have full, unrestricted clinical privileges at the Millard Fillmore Hospital. (T. 795-797)

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.

The Hearing Committee concluded that all Factual Allegations set forth in the Department's Notice of Hearing and Statement of Charges (Ex. 1) should be **SUSTAINED.** The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A.:	(1-2, 15-17);
Paragraph A.1.:	(3-4);
Paragraph A.2.:	(5-8);
Paragraph A.3.:	(9-14);
Paragraph B.:	(18, 39);
Paragraph B.1.:	(19-23, 25-28);
Paragraph B.2.:	(24, 30-32, 40-41);
Paragraph B.4.:	(33-41);
Paragraph C.:	(42, 59);

Paragraph C.1.:	(43-45);
Paragraph C.2.:	(46-48);
Paragraph C.3.:	(50-56);
Paragraph C.4.:	(50-58);
Paragraph C.5.:	(50-58);
Paragraph D.:	(60);
Paragraph D.1.:	(65-73);
Paragraph D.2.:	(67-74);
Paragraph D.3.:	(67-74);
Paragraph E.:	(75);
Paragraph E.1.:	(76-77);
Paragraph E.2.:	(78-82);
Paragraph E.3.:	(86-93);
Paragraph E.4.:	(86-96);
Paragraph E.5.:	(86-96).

The Hearing Committee concluded that the following Specifications should be **SUSTAINED** based upon the Factual Allegations which were **SUSTAINED:**

Eleventh Specification;

Twelfth Specification.

The Hearing Committee concluded that the following Specification should **NOT BE SUSTAINED:**

First through Tenth Specifications.

DISCUSSION

Respondent was charged with multiple 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 the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, and 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 reasonable prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician 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 the 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 medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee determined that the Department had established, by a preponderance of the evidence, all Factual Allegations set forth in its Statement of Charges. The Committee further determined that such Factual Allegations constituted the practice of medicine with negligence and incompetence on more than one occasion, but did not constitute the practice of medicine with gross incompetence or gross negligence on a particular occasion. The rationale for these determinations is set forth below.

The Committee recognized that the critical issue of this proceeding was to establish what was the acceptable standard of medical practice appropriate in each of the five cases at hand. It was therefore essential to evaluate the testimony presented by the two medical experts to determine the appropriate weight to be given to their responses. The Committee considered both Dr. Vinciguerra and Dr. Howard to be well-qualified and extremely knowledgeable about the practice of obstetrics and gynecology. Dr. Vinciguerra was noted to be currently active in the private practice of medicine through the Albany Medical College as well as an Associate Professor with that institution's Department of Obstetrics and Gynecology. Dr. Howard testified that he remains in private practice but has reduced his obstetric practice during the past few years. He stated that he was also director of the Department of Obstetrics and Gynecology at White Plains Hospital for about eight years and has been director emeritus since 1988.

The Committee believed Dr. Vinciguerra to be forthright and considered his testimony to be objective and authorative. The members felt that he did not volunteer opinions and that those opinions which he expressed were rational and based on solid reasoning. The Committee gave Dr. Vinciguerra's testimony great weight in reaching its' determinations. The Committee considered Dr. Howard's testimony to be honest, but it was perceived to be presented in a manner which attempted to minimize the significance of Respondent's actions and to place those actions in an unreasonably favorable light. It was noted that he characterized many of the Respondent's actions as "errors in judgement" rather than professional misconduct, but also appeared to indicate that he would require close monitoring of the Repondent if he were ever to be given privileges in a Department of which Dr. Howard was chairman. (T. 1072-3) In fact, the Committee believed that there were several instances in which Dr. Howard questioned Respondent's actions or judgements and disagreed with the course of treatment rendered by him. His testimony was considered to be less objective than Dr. Vinciguerra's and actually supportive of certain positions of the Department which were raised in the Statement of Charges. Accordingly, his testimony was not relied upon as greatly by the Committee in arriving at its conclusions.

CONCLUSIONS AS TO PATIENT A

The Committee considered it necessary for Respondent to adequately monitor Patient A's second twin to assess its condition following the birth of the first twin. Dr. Vinciguerra testified that fetal assessment would include an assessment of its' heart rate and the presence of any complications. Respondent testified that the fetal monitoring belt could not be maintained on the second twin and that a continuous tracing could not be obtained. In the absence of continuous monitoring, Respondent relied upon a nurse who manually repositioned the monitor and listened about once every minute for the fetal heartbeat. The committee relied upon Dr. Vinciguerra's opinion that the tracings on the fetal monitoring strip were inadequate to monitor the fetus. It concluded that Respondent was so focused on the delivery of Twin B that he did not adequately monitor its condition. The fact that the baby had respiratory difficulties at birth and a cord ph indicative of acidosis was noted as supportive of the consideration that the baby suffered from a diminished oxygen supply. The Committee considered the reduction of oxygen supply to be evidence of inadequate fetal monitoring and sustained Factual Allegation A.1.

The Committee considered Respondent's actions in applying the vacuum extractor to Twin B without adequately determining the baby's position and presentation to be a clear case of professional misconduct. The minimally accepted standard of medical practice in the delivery of twins was not considered to always require the performance of an ultrasound to establish the position and presentation of a second twin following the delivery of the first. However, Respondent testified that he believed Twin B to be a breech following his palpation of the baby's presenting parts. He stated that this presentation was consistent with the fetal positioning throughout Patient A's labor (T. 644) He also acknowledged that with the delivery of the first twin, there was space in the uterus for Twin B to move. (T. 651) The Committee felt that the fact that Respondent was delivering a second twin, described by Respondent as "a very unique circumstance in obstetrics" (T. 651), compounded by the fact that he believed this twin to be a breech presentation, required him to accurately determine the presentation before attempting the delivery. It considered the Respondent

to be unreasonably overconfident, under the circumstances, in his belief that the baby was in a breech presentation and that he should have actually been uncertain of the presentation. Being uncertain, the Committee felt Respondent should have performed an ultrasound to verify the presentation. The fact that the hospital had no general policy requiring the performance of an ultrasound between all deliveries of twins was not considered to be relevant under the circumstances of this particular case. The absence of a general policy was not considered to be a legitimate basis for Respondent to not meet the acceptable level of care in the specific case of his treatment of Patient A.

The Committee agreed with the testimony of Dr. Vinciguerra and Dr. Choate that a vacuum extractor should only be applied to the fetal head and not to a non-vertex presenting portion of a fetus. Therefore, it considered it unnecessary to determine whether Respondent should have known, after palpating the fetus, that it was in a transverse lie presentation. Respondent testified that he believed the baby to be in a breech presentation and, therefore, inappropriately applied the vacuum extractor in an attempt to deliver Twin B. Factual Allegation A.3. was sustained.

CONCLUSIONS AS TO PATIENT B

The Committee felt Dr. Vinciguerra was the more credible witness in his testimony that the artificial rupture of membranes in the presence of an unengaged fetal head should only be undertaken in an emergency situation when a setup for a Cesarean section is present. Respondent testified that it was preferable to rupture membranes in a controlled situation to enable a physician to promptly diagnose a cord prolapse and to immediately perform a Cesarean section if a prolapse were to occur. (T. 601-602) However, in the case of Patient B, Respondent did not have a setup for a Cesarean section when he artificially ruptured her membranes at 3:45 p.m. on April 3, 1990 and did not have such a setup available until over five (5) hours later. Factual Allegation B.1. was sustained.

The Committee considered the augmentation of Patient B's labor with Pitocin at 6:45 p.m. to be inappropriate. Three (3) hours after the patient's membranes were artificially ruptured, the station of the baby was noted as minus one (-1) with molding present. The Hearing Committee agreed with Dr. Vinciguerra's assessment that the descent of the baby was limited following a three (3) hour trial of labor, that the head remained unengaged and that Respondent had recorded "probable CPD" at 3:45 p.m. It concluded that the lack of progress by 6:45 p.m. made augmentation of the labor inappropriate in that Patient B had already arrested following a trial of labor. Factual Allegation B.2. was sustained.

The Committee relied upon the testimony of Dr. Burdick, the attending anesthesiologist, and Dr. Gullo, a senior obstetrician/gynecologist with whom Respondent consulted in the delivery of the baby, to conclude that Respondent applied traction when attempting to place the forceps. The Committee considered Dr. Burdick to be an objective witness with no interest in the outcome of this proceeding. He testified that he could clearly observe the attempts made to deliver the baby by forceps. Dr. Burdick was firm in his testimony that Respondent applied traction while Dr. Gullo did not. (T. 91, 93) Dr. Burdick's testimony was viewed as corroboration of Dr. Gullo's denial of having applied traction. (T. 137, 150)

The record was clear, and Respondent admitted, that he was unable to successfully lock either of the sets of the forceps he attempted to apply to the fetal head. The Committee agreed with the testimony of Dr. Vinciguerra that forceps should be properly locked or articulated as an indication that they are correctly applied to the baby's head. In addition, Respondent noted at 6:45 p.m. that the baby's head was molded and the hospital records verified that the baby was born with severe and marked molding. The Committee believed Respondent should have recognized that the extensive molding would make it harder to determine the position of the head and would make any forceps delivery more difficult. Respondent should have also realized that the inability to properly apply two sets of forceps was an indication that CPD may have been present in addition to the molding.The Committee concluded that applying traction to unlocked forceps with the

knowledge that molding and possibly CPD were present was a significant deviation from acceptable standards of care and voted to sustain Factual Allegation B.4.

CONCLUSIONS AS TO PATIENT C

The Committee reviewed Exhibit L, which was the complete history of Patient C's prenatal record, and concluded that there was no indication of any evaluation of the patient's pelvic capacity to deliver, other than a note of "NL" made early in her pregnancy. Respondent testified that he did perform a pre-induction evaluation, but failed to record his findings. (T. 695) The Committee considered the absence of findings of any pre-induction evaluation to be of greater significance than a mere recordkeeping violation and determined to sustain Factual Allegation C.1. The members believed that since the induction of labor was elective, all circumstances upon which such elective procedure was based should have been expressly noted in the patient's record. If the basis for induction was that the baby was large for its gestational age, the absence of any estimate of fetal size was viewed as a deviation from the accepted standard of care.

The Hearing Committee was troubled by the discrepancies in the patient's medical record as to the reason for the induction of labor. The hospital admitting certification signed by Respondent indicated "induction for LGA" (Ex. 6, p. 29) However, Respondent made no mention of the estimated fetal size in his operative report. (Ex. 6, p. 62) As noted above, the prenatal history also made no reference to the fetal size. The Committee also noted Respondent's own contradictory statement as to the baby's size. He first stated that he was concerned about the size of the baby, but later testified that he believed patient C could deliver vaginally because he "didn't think the baby was that large". (T. 693, 695) The members of the Committee concluded that there were insufficient medical indications to justify the induction of the patient's labor. Factual Allegation C.2. was sustained.

Patient C became fully dilated at about 9:00 p.m. and was evaluated by Respondent at approximately 12:05 a.m. Three (3) hours after full dilatation, Respondent observed the baby's head remaining high. At that time, he recorded his plan as discontinuing the Pitocin and allowing the patient to rest and resume pushing a few hours thereafter. Respondent soon thereafter left the hospital and did not return to personally evaluate the patient until approximately 7:10 a.m. Hospital records indicate that the Pitocin was not turned off and, in fact, continued to be administered throughout that period of about seven (7) hours. Therefore, the patient never actually did rest. The Committee agreed with Dr. Vinciguerra's opinion that Respondent failed to examine the patient in a timely manner to investigate the cause of the protracted second stage of labor. It dismissed Respondent's testimony that he believed the arrest in delivery was due to inadequate pushing powers on the part of the patient. (T. 701-703) The members of the Committee believed that such a consideration did not warrant a period of rest for at least four hours (from 1:10 a.m. to 5:30 a.m.) and a period of not examining the patient of about seven (7) hours. Respondent's plan recorded at 12:05 a.m. failed to address how long the patient should be permitted to rest and thereafter to push. The Committee believed his presence in the hospital was necessary to address potential problems and concluded that his absence for such a length of time deviated from acceptable standards of care. Factual Allegations C.3. and C.4. were sustained.

The Hearing Committee also agreed with Dr. Vinciguerra's assessment that the slow rate of descent of the baby, despite the continuation of Pitocin, should have caused the Respondent to recognize that a vaginal delivery of Patient C's baby was not possible and that a Cesarean section should have been performed earlier. The Committee felt that had Respondent evaluated the patient earlier than about 7:10 a.m., he could have determined that the Pitocin had not actually been discontinued. Factual Allegation C.5 was sustained.

CONCLUSIONS AS TO PATIENT D

Patient D was admitted at about 10:00 a.m. on November 2, 1993 in the early stages of labor. Her membranes were artificially ruptured at about 6:00 p.m. following an examination and evaluation of the patient by Respondent. He shortly thereafter left the hospital and telephoned an order to administer Pitocin to augment labor at about 7:45 p.m. Respondent did not order discontinuance of Pitocin until about 3:10 a.m. on the following day. Respondent was notified, by telephone, at about 10:30 p.m. that the patient was fully dilated. The Respondent was notified, by telephone, at about 1:00 a.m. that no progress had been noted despite two (2) hours of pushing by the patient and at approximately 3:10 a.m. that the patient's amniotic fluid was observed to be yellow, variability was decreased and variable decelerations were occurring. Nevertheless, Respondent failed to return to the hospital to personally examine the patient until about 4:30 a.m., or about six (6) hours after the second stage of labor had begun and about ten and one-half (10 1/2) hours after his last examination of her.

The Committee believed Respondent's treatment of Patient D to be not within acceptable standards of practice. It should have been clear to Respondent that the patient was experiencing a labor progression disorder and the Committee concluded that he should have been present to address that situation. The patient had experienced an arrest of her first stage of labor by about 6:00 p.m. when her membranes were artificially ruptured. Despite augmentation with Pitocin for at least five (5) hours and full dilatation for two and one-half (2 1/2) hours, the patient's labor had not progressed by 1:00 a.m., signifying a second stage arrest of labor. The Committee felt that a personal examination of the patient by Respondent would have been appropriate at that time and would have been even more necessary at 3:10 a.m. after the patient had rested and the Pitocin was discontinued.

The members of the Hearing Committee also determined that Respondent was made aware of the possible presence of meconium in the amniotic fluid. It considered the testimony of both Dr. Vinciguerra and Dr. Choate, that meconium stained amniotic fluid could be a sign of some level of fetal distress, as lending further support to the need for Respondent to evaluate the status of the fetus

and mother. (T. 76, 117-119, 266-267) It was noted that the presence of meconium staining was recorded on the labor and delivery summary, signed by Respondent. (Ex. 7, p. 46) However, Respondent chose to not evaluate the patient until over an hour after learning of the presence of yellowish amniotic fluid. The Committee determined to sustain Factual Allegations D.1., D.2., and D.3. based on the conclusion that Respondent failed to properly monitor and evaluate the causes of the patient's protracted labor.

CONCLUSIONS AS TO PATIENT E

The allegations related to Patient E were very similar to those related to Patient C, and the Committee viewed Respondent's care of the two (2) patients to also be very similar. As with Patient C, Respondent recorded no evaluation of Patient E's pelvic capacity or estimation of fetal size other than noting "NL" on the prenatal record early in her pregnancy. Respondent testified that he had ordered the induction of labor because the baby was bordering on being macrosomic. (T. 729-30) There was no documentation of the baby's estimated weight anywhere in Patient E's record, including in the prenatal or obstetric admitting record. (Ex. 8, pp. 27-28) As before, the Committee believed that because the induction was elective, the reasons for such elective procedure should have been clearly documented. While Respondent testified that he did assess the patients pelvic capacity, estimated fetal weight and the possibility of CPD (T.730), the panel concluded that the absence of any documented findings of such assessments constituted a deviation from accepted medical standards of practice. Factual Allegation E.1. was sustained.

The Committee observed that the discrepancies in the reasons for the induction of Patient E as given by Respondent were not clarified by the medical charts. He stated that she was one (1) week overdue in her delivery and that was the basis for his signing the certification of admission. (Ex. 8, p. 29; T. 729) In the absence of any other medical justification, the Hearing Committee felt that the induction because Patient E was one (1) week overdue was not an adequate medical

indication. There was no mention in the record of any consideration by Respondent that the baby could be macrosomic. In addition, both Dr. Vinciguerra and Dr. Howard agreed that Patient E's cervix was not favorable for induction because she was not dilated, was only 70% effaced and the baby's head was not engaged. (T. 276-277, 1043) Factual Allegation E.2. was sustained.

Respondent ordered the administration of Pitocin at about 7:50 a.m. on February 3, 1995. He ruptured her membranes at about 1:00 p.m. The patient was noted to only be dilated three (3) to four (4) centimeters and 90% effaced at approximately 9:30 p.m., at about which time Respondent left the hospital. The patient reached full dilatation at about 2:20 a.m. on the following day. At approximately 4:05 a.m., Respondent was advised, by telephone, of her status and recommended that she be allowed to rest. She was rested approximately forty five minutes and then resumed pushing. At about 5:30 a.m. Respondent was again telephoned and told that the patient had made no further progress. He ordered the Pitocin discontinued and the patient rested again. The patient rested for about one (1) hour and Pitocin again was started at about 6:45 a.m. Respondent personally examined that patient at about 7:10 a.m., which was at least nine (9) hours after his previous examination of her. The Hearing Committee believed that the Respondent failed to meet acceptable standards of medical care by not personally examining the patient in a timely manner to determine the cause of her prolonged labor. The patient's labor was augmented by Pitocin continuously for almost seventeen (17) hours before she reached full dilatation. Respondent had a duty to investigate the cause of the arrest of the baby's descent. The members of the Committee felt that Respondent's obligation to make such investigation was made greater by his belief that the baby was macrosomic and that he should have recognized that the limited rate of descent in the face of continued administration of Pitocin for an extended period may have made vaginal delivery of Patient E's baby impossible. The Respondent permitted the patient's second stage to continue over seven (7) hours before deciding that a Cesarian section would be appropriate. The Hearing Committee concluded that this length of time was excessive in light of the patient's condition and lack of progress in delivering her baby. Factual Allegations E.3., E.4, and E.5. were each sustained.

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Committee utilized the above-cited definition of negligence in determining to sustain the Eleventh Specification in the Department's Statement of Charges. The determination was based upon the particular circumstances of each patient's treatment and care by the Respondent. The Committee concluded that Respondent failed to provide that care expected of a reasonably prudent physician in the unique circumstances of each of the five (5) patients. The members of the Hearing Committee found it unnecessary to decide wide-ranging issues such as whether the appropriate standard of care mandates that an ultrasound be performed between all twin deliveries or requires a second stage of labor to be of a fixed length of time. The fact that the hospital had no specific policy which required the presence of a physician during the entire second stage of labor was similarly considered not relevant to the determination of what was the acceptable standard of medical care. The Committee believed that the absence of a general policy did not relieve Respondent from his responsibility to perform an ultrasound or personally examine a patient if the circumstances of a case necessitated such an action.

In the case of Patient A, Respondent should have recognized that the presentation of the second twin was uncertain and consequently that he was required to take further action to ascertain whether an attempt at a vacuum assisted delivery would have been appropriate. The Committee felt that a reasonably prudent physician would not have attempted the forceps delivery of Patient B's baby when the forceps could not be properly articulated and when the fetal head was unengaged with molding present. It concluded that Respondent was negligent in not personally examining Patient C for over seven (7) hours in light of an obvious protracted second stage of labor; in not evaluating Patient D for approximately six (6) hours while he was aware that the patient was experiencing a lack of progress in her second stage and that signs of fetal distress had been noted; and in failing to evaluate the cause of Patient E's protracted second stage of labor for approximately five (5) hours. The Committee believed that Respondent's negligence in failing to examine Patients C and E was made greater by the fact that he chose to electively induce labor because of concerns

of the size of the fetus. It was concluded that if Respondent considered the two (2) babies to possibly be macrosomic, the reasonably prudent physician would have personally evaluated the pelvic capacity of Patients C and E in a timely manner to ensure that CPD was not present.

It was also the conclusion of the Hearing Committee that the fact that no patient or baby suffered significant injury was not relevant in determining whether Respondent was guilty of professional misconduct. It agreed with Dr. Vinciguerra's assessment that outcome is not related to what is considered to be an acceptable standard of practice. (T. 399-400) The Committee believed that the fact that a patient survived an inappropriate treatment did not make such treatment acceptable.

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The Committee believed that Respondent demonstrated a lack of the skill and knowledge necessary to practice medicine in his treatment and care of the five (5) patients. It noted that the application of a vacuum extractor to a non-vertex presenting portion of a twin whose presentation is not certain, the artificial rupture of membranes in the presence of an unengaged head followed by augmentation of labor, the application of traction to unlocked forceps in the presence of significant molding and possible CPD, the failure to properly document the medical basis for the elective induction of labor and the failure to personally examine patients during prolonged second stages of labor each indicated an absence of the requisite skill, knowledge and judgement to safely practice. The Committee had concerns that some of Respondent's testimony, such as his statement that a cord prolapse is not necessarily an emergency (T. 854) and his testimony related to fetal head engagement (T. 636-638) indicated a lack of familiarity with certain basic medical concepts. The allegations of misconduct related to the failure to evaluate in a timely manner the three (3) protracted second stage of labor patients (Patients C, D and E) were considered to reflect Respondent's absence of knowledge of the necessity to be present in situations in which there has been an arrest of descent.

The Committee believed the actions of the Respondent characterized by Dr. Howard as errors in judgement to be more indicative of a lack of the skill necessary to conduct a medical practice. The Twelfth Specification was sustained.

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE OR GROSS INCOMPETENCE

The Committee determined that the Department did not demonstrate by a preponderance of the evidence that Respondent's conduct was so egregious as to constitute gross negligence or that he demonstrated such an unmitigated lack of skill or knowledge as to constitute gross incompetence.

The Committee considered that Respondent misdiagnosed what he believed to be the breech presentation of Patient A's second twin and did not knowingly apply the vacuum extractor to a fetus in a transverse lie presentation. It noted his testimony that his notation of "probable CPD" in Patient B's case was to alert him to that possibility and was not an actual diagnosis of that condition. (T. 603, 611) While this testimony was viewed as mitigating, the Committee also noted Respondent's postoperative diagnosis of the presence of CPD, which it relied upon to sustain charges of "simple" negligence and incompetence. (Ex. 5, p. 45) The members of the Hearing Committee viewed the conflict in expert medical testimony and literature regarding the duration and management of the second stage of labor as mitigating evidence which supported the determination to not sustain specifications of gross negligence and gross incompetence. The fact that there is no agreement on certain broad aspects of the management of second stages of labor supported the determination that Respondent, in his treatment of Patients C, D and E, did not fail in a conspicuously bad manner to exercise the care expected of a reasonably prudent physician. Finally, the Committee considered the action in December, 1993 by Respondent's Clinical Chief in which he indicated that no deviations from the accepted standard of care had been found in Respondent's practice during the previous six (6) months to be a factor mitigating against a finding of gross

negligence or gross incompetence in his treatment of Patient C and E. However, as will be addressed below, the Committee did not believe that the actions of the hospital or Clinical Chief precluded it from determining that Respondent's care of the five (5) patients constituted professional misconduct.

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 in New York State should be suspended until he completes an evaluation of his skills and a course of retraining, as described more fully in the Order below. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

In reaching this determination, the Committee considered the history of Respondent's clinical privileges at the Millard Fillmore Hospital. It noted that his privileges were restricted in 1990 and again in 1993. The Committee felt that two restrictions within a few years should have alerted the facility to the fact that greater oversight of the Respondent's practice was necessary. The cursory manner in which he was notified in December, 1993 that the restrictions on his privileges were removed was viewed as being insufficient in addressing Respondent's practice as a physician and the Committee felt that by imposing a penalty following this proceeding it was performing a function that should have been undertaken earlier by the hospital.

Respondent repeatedly raised the argument that the December 21, 1993 letter, which advised him of no finding of further deviations in his care during the previous six (6) months, caused him to believe his treatment of Patient D was acceptable. He contended that his treatment of Patients C and E in a like manner subsequent to the issuance of that letter should, therefore, also be considered as acceptable. The Committee rejected this argument. It considered its responsibilities to determine

violations of professional misconduct pursuant to the Public Health Law as being independent of any actions undertaken by a hospital at which Respondent had clinical privileges. It further rejected the argument that the Respondent's treatment of Patients C and E was performed in reliance upon the hospital's approval of the manner in which Patient D was treated. The Committee believed that Respondent was required to meet an accepted standard of care with each patient he treated and that it was not met in any of the three (3) prolonged second stage cases.

The Committee concluded that a suspension, rather than revocation, of Respondent's license would be most appropriate in this instance. It believed that he demonstrated in his testimony the motivation to improve his skills which must be present to make any retraining viable. It was noted that Respondent testified that his experiences in the cases of the five patients have caused him to modify some of his previous practices. This led the Committee to believe that he has a willingness to correct certain deficiencies and would be receptive to further education. He did not appear to be argumentative and seemed able to accept criticism. The members of the Hearing Committee also believed that the Respondent was not without some ability and insight and that a rigorous retraining program would assist him in raising his skills to an acceptable level. The relatively young age of the Respondent was also considered a factor in the Committee's conclusion that a license suspension coupled with retraining would be the most appropriate penalty.

ORDER

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

1. The Eleventh and Twelfth Specifications, as set forth in the Statement of Charges (Ex. 1), are **SUSTAINED;** and

2. The First through Tenth Specifications, as set forth in the Statement of Charges (Ex. 1), are **NOT SUSTAINED,** and are **DISMISSED;**

3. The license of Respondent, Joachim Amato, M.D., shall be **SUSPENDED** until such time as he shall successfully complete a course of retraining as set forth below; and

4. At Respondent's expense, Respondent shall complete the Phase I Evaluation of the Physician Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center, Syracuse, New York, within ninety (90) days of the effective date of this Order; and

    a. If the Phase I Evaluation indicates that Respondent is a candidate for re-education, then Respondent shall successfully complete Phase II of the PPEP at Syracuse, the pilot New York State Physician Retraining Program (PRP), or an equivalent program, such as a residency or mini-residency, and Phase III, the post-training evaluation, and

b. Should Respondent be found not a candidate for re-education and unsuitable for training as set forth above, Respondent shall enroll in and complete a program of retraining in the area of Obstetrics and Gynecology to be equivalent to a six month residency program. Said program of retraining shall be subject to the approval of the director of the Office of Professional Medical Conduct; and

5. Respondent shall be permitted to practice medicine to the extent necessary for his evaluation and re-training.

6. Following his successful completion of the evaluation and retraining requirements, as set out in Paragraphs Two through Four above, Respondent shall be placed on **PROBATION** for a period of two (2) years, in accordance with the terms set out in Appendix II of this Determination and Order.

DATED: Albany, New York
June 21, 1995

LEMUEL A. ROGERS, JR., M.D.
Chairperson

JOHN P. FRAZER, M.D.
IRVING S. CAPLAN

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JOACHIM AMATO, M.D.	:	CHARGES
Respondent	:	

----------X

JOACHIM AMATO, M.D., the Respondent, was authorized to practice medicine in New York State on March 11, 1983 by the issuance of license number 153319 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1993 through December 31, 1994 with a current registration address of 6546 East Quaker Street, Orchard Park, New York 14127.

FACTUAL ALLEGATIONS

A. Respondent provided obstetrical care to Patient A (all patients are identified in the attached Appendix) at Millard Fillmore Suburban Hospital, 1540 Maple Road, Williamsville, New York (hereinafter "Millard Fillmore Hospital") from on or about June 3, 1993 through approximately June 7, 1993. Patient A was admitted on or about June 3, 1993 with a known twin gestation. After delivery of the first infant via vacuum extraction, the second infant was ultimately delivered via Cesarean Section and required resuscitation. The infant's cord pH demonstrated severe

acidosis and the infant was found to have signs of brachial palsy. Respondent failed to appropriately manage Patient A's labor and delivery, in that:

1. Respondent, after delivery of the first infant, failed to adequately monitor and/or assess the second infant for fetal status/well being.

2. Respondent failed to perform adequate procedures to determine the presentation and position of the second infant prior to attempting a vacuum extraction.

3. Respondent inappropriately utilized a vacuum extractor in an attempt to deliver the second infant.

B. Respondent provided obstetrical care to Patient B at Millard Fillmore Hospital from on or about April 3, 1990 through approximately April 7, 1990. A female infant was ultimately delivered via Cesarean Section and was found to have a fractured skull. Respondent failed to appropriately manage Patient B's labor and delivery, in that:

1. Respondent inappropriately ruptured Patient B's membranes in the presence of an unengaged vertex.

2. Respondent inappropriately augmented Patient B's labor in the presence of molding, dilation of nine centimeters and documentation that there was "probable CPD".

3. Respondent inappropriately attempted a forceps delivery of this infant.

deleted per Dept motion 11/17/94 jd

4. Respondent inappropriately applied traction with [the] forceps.

11/17/94 jd

C. Respondent provided obstetrical care to Patient C at Millard Fillmore Hospital from on or about December 22, 1993 through approximately December 26, 1993. Patient C was admitted on or about December 22, 1993 for induction of labor. A female infant was delivered at approximately 8:35 a.m. the next morning with a temperature of 101 degrees. Respondent failed to appropriately manage Patient C's labor and delivery, in that:

1. Respondent failed to perform an adequate pre-induction evaluation.

2. Respondent induced labor without adequate medical indication.

3. Respondent, after resting Patient C, failed to personally examine and/or adequately evaluate her for fetal status and/or pelvic capacity in a timely manner prior to allowing labor to continue.

4. Respondent allowed Patient C to have an excessively protracted and/or arrested second stage of labor of approximately twelve hours without adequate and/or timely evaluation.

5. Respondent failed to perform a Cesarean Section in a timely manner.

D. Respondent provided obstetrical care to Patient D at Millard Fillmore Hospital from on or about November 2, 1993 through approximately November 5, 1993. Respondent failed to appropriately manage Patient D's labor and delivery, in that:

1. Respondent, after resting Patient D during a protracted second stage of labor, failed to personally examine and/or adequately evaluate Patient D for cephalopelvic disproportion in a timely

manner before allowing labor to continue.

2. Respondent, prior to allowing labor to continue, failed to personally examine and/or adequately evaluate this patient for fetal status in a timely manner, despite his notification of the presence of Meconium stained amniotic fluid, decreased fetal heart variability and variable decelerations.

3. Respondent allowed Patient D to have an excessively protracted and/or arrested second stage of labor of approximately 7 hours without adequate and/or timely evaluation.

E. Respondent provided obstetrical care to Patient E at Millard Fillmore Hospital from on or about February 3, 1994 through approximately February 7, 1994. Patient E was admitted on or about February 3, 1994 for induction of labor. Respondent failed to appropriately manage Patient E's labor and delivery, in that:

1. Respondent failed to perform an adequate pre-induction evaluation.

2. Respondent induced labor without adequate medical indication.

3. Respondent, after resting Patient E, failed to personally examine and/or adequately evaluate Patient E for fetal status and/or pelvic capacity in a timely manner, prior to resuming labor.

4. Respondent allowed Patient E to have an excessively protracted and/or arrested second stage of labor of approximately seven hours without adequate and/or timely evaluation.

5. Respondent failed to perform a Cesarean Section in a timely manner.

SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1994) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, and/or A.3.
2. The facts in Paragraphs B and B.1, B.2, B.3 and/or B.4.
3. The facts in Paragraphs C and C.1, C.2, C.3, C.4 and/or C.5.
4. The facts in Paragraphs D and D.1, D.2 and/or D.3.
5. The facts in Paragraphs E and E.1, E.2, E.3, E.4 and/or E.5.

SIXTH THROUGH TENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(6) (McKinney's Supp. 1994) by reason of his having practiced the profession with gross incompetence, in that Petitioner charges:

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

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

8. The facts in Paragraphs C and C.1, C.2, C.3, C.4 and/or C.5.

9. The facts in Paragraphs D and D.1, D.2 and/or D.3.

10. The facts in Paragraphs E and E.1, E.2, E.3, E.4 and/or E.5.

ELEVENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed medical misconduct under N.Y. Educ. §6530(3) (McKinney's Supp. 1994) by reason of his having practiced the profession with negligence on more than one occasion, in that Petitioner charges that the Respondent committed at least two of the following:

11. The facts contained in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4 and/or E and E.5.

TWELFTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed medical misconduct under N.Y. Educ. Law §6530(5) (McKinney's Supp. 1994) by reason of his having practiced the profession with incompetence on more than one occasion, in that the Petitioner charges that the Respondent committed at least two of the following:

12. The facts contained in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4 and/or E and E.5.

DATED: Oct. 7, 1994
Albany, New York

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II
TERMS OF PROBATION

1. Dr. Amato shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Dr. Amato shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. Amato shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, facility affiliation, residence or telephone number, within or without of New York State.

4. In the event that Dr. Amato leaves New York to reside or practice outside the State, he shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residence or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Amato's probation shall be supervised by the Office of Professional Medical Conduct.

6. Dr. Amato shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings, his professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed. Dr. Amato will make available for review by the Office of Professional Medical Conduct complete copies of any and all medical and office records selected by the Office of Professional Medical Conduct. Dr. Amato will maintain legible and complete medical record which accurately reflect evaluation and treatment of patients. Records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

7. Dr. Amato shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If he elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

8. All expenses, including but not limited to those of complying with these terms of probation and the Determination and Order, shall be the sole responsibility of Dr. Amato.

9. Dr. Amato shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against him pursuant to New York Public Health law §239(19) or any other applicable laws.

DENNIS C. VACCO
Attorney General

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

DONALD P. BERENS, JR.
Deputy Attorney General

(212) 416-8565

November 21, 1995

Connors & Vilardo
1020 Liberty Building
420 Main Street
Buffalo, New York 14202

Att'n: Lawrence Vilardo, Esq.

Re: Matter of Amato v. New York State Department Of Health, #74880

Dear Mr. Vilardo:

Enclosed please find an order of the Appellate Division, Third Department decided and entered November 16, 1995. The stay of the revocation of petitioner's license imposed by the respondents will be automatically vacated on December 1, 1995. We have informed the Health and Education Departments of the date that the revocation becomes effective.

Very truly yours,

RAYMOND J. FOLEY
Assistant Attorney General

RJF:bw
Enclosure

cc: Gus Martine, Supervising Investigator
Hal Rosenthal, Esq.

Supreme Court - Appellate Division
Third Judicial Department

Decided and Entered: November 16, 1995 Case #: 74880

In the Matter of JOACHIM AMATO, Petitioner,
v
STATE OF NEW YORK DEPARTMENT OF HEALTH et al., Respondents.

DECISION AND ORDER ON MOTION

Motion for stay pending determination of review proceeding.

Upon the papers filed in support of the motion, and the papers filed in opposition thereto, it is

ORDERED that the motion is denied, without costs.

MIKOLL, J.P., MERCURE, CREW III, WHITE and CASEY, JJ., concur.

ENTER:

Michael J. Novack
Clerk of the Court