



# STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.  
*Commissioner*

Paula Wilson  
*Executive Deputy Commissioner*

November 8, 1993

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Merab Boter, M.D.  
170 Old Country Road  
Riverhead, New York 11901

Ralph J. Bavaro, Esq.  
NYS Department of Health  
5 Penn Plaza - Sixth Floor  
New York, New York 10001

Walter R. Marcus, Esq.  
Kern, Augustine, Conroy  
& Schoppman  
420 Lakeville Road  
Lake Success, NY 11042

**RE: In the Matter of Merab Boter, M.D.**

Dear Dr. Boter, Mr. Marcus and Mr. Bavaro:

Enclosed please find the Determination and Order (No. ARB 93-58) 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.

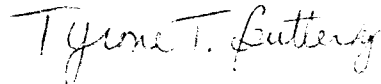
Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct  
New York State Department of Health  
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 than 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)].

Very truly yours,



Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:rg  
Enclosure

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

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IN THE MATTER	:	<u>ADMINISTRATIVE</u>
	:	<u>REVIEW BOARD</u>
OF	:	<u>DETERMINATION</u>
	:	<u>AND ORDER</u>
MERAB BOTER, M.D.	:	<u>ARB NO. 93-58</u>

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The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of **ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on July 6, 1993 to review the Professional Medical Conduct Hearing Committee's (Committee) April 16, 1993 Determination finding Dr. Merab Boter guilty of professional misconduct. Both the Respondent and the Office of Professional Medical Conduct (OPMC) requested the review through Notices which the Review Board received on May 3, 1993 and May 4, 1993. James F. Horan served as Administrative Officer to the Review Board. Ralph J. Bavaro, Esq. submitted a brief for OPMC on May 13, 1993 and a response on June 14, 1993. Walter R. Marcus, Esq. submitted a brief for Dr. Boter on June 1, 1993 and a response to OPMC's brief on May 20, 1993.

### 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 Office of Professional Medical Conduct charged the Respondent with Negligence on more than one occasion, incompetence on more than one occasion, gross negligence and gross incompetence. The charges arose from the care which the Respondent provided to four patients, A through D.

The Hearing Committee sustained the charge that the Respondent was negligent on more than one occasion for his treatment of Patients A, B and D. The Committee did not sustain the charges of incompetence on more than one occasion, gross incompetence or gross negligence.

The Hearing Committee voted to suspend the Respondent's license for three years, stayed the suspension and placed the Respondent on probation for one year. The probation terms require that the Respondent obtain a monitor and that the monitor report to OPMC every three months concerning the quality of the Respondent's practice. The Hearing Committee's Order provides that if the Respondent completes the probation satisfactorily, the suspension shall be lifted. If the Respondent fails to comply with the conditions of probation, the Committee's Order provides that the suspension will be reinstated automatically.

#### **REQUESTS FOR REVIEW**

The Office of Professional Medical Conduct questions whether Public Health Law Section 230-a allows the Hearing Committee to lift the Respondent's suspension if he successfully completes his probation. OPMC also questions whether the Hearing Committee can order that the suspension of the Respondent's license can be automatically reinstated, without a violation of probation proceeding, if the Respondent does not comply with the terms of probation. OPMC asks that the Review Board remove those two provisions from the penalty and adopt a modified order that would extend the Respondent's period of probation to three years and require that the Respondent obtain second surgical opinions concurring with all planned surgery and, where practicable, concurring with emergency surgery.

The Respondent contends that the Hearing Committee's Determination that the Respondent was guilty of negligence on more than one occasion and the Committee's penalty are not consistent with the Committee's findings and conclusions; and that the findings are erroneous, inconsistent with the hearing testimony and insufficient to sustain the Committee's Determination. The Respondent contends further that the Hearing Committee's penalty is unduly harsh.

The Respondent asks that the Review Board vacate the Hearing Committee's penalty. In the alternative, the Respondent asks that the Review Board reduce the period of the stayed suspension in this case to one year. In the alternative to that request, the Respondent asks that the Review Board not increase the period of probation and add new probationary terms, as OPMC requests.

#### **REVIEW BOARD DETERMINATION**

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

The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was guilty of negligence on more than one occasion for the Respondent's treatment of Patients A, B and D. The Determination is consistent with the Committee's findings and conclusions concerning the sub-standard care that the Respondent provided to those patients.

The Review votes to overturn the Hearing Committee's penalty imposing a suspension, stayed, and one year on probation, with a monitor, because that penalty is totally inadequate and inappropriate to deal with the shortcomings in the Respondent's surgical skills. The Review Board votes to limit the Respondent's license to prohibit him from practicing surgery and we vote to refer the Respondent for an evaluation of his skills as a physician at the Physician Prescribed Education 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.<sup>1</sup>

The Hearing Committee found and concluded that the Respondent had committed repeated acts of negligence in the surgical care which he provided to Patients A, B, and D. The Committee found that the Respondent proceeded with a Whipple Resection procedure on Patient A after finding a metastatic adenocarcinoma in the patient's liver (FF 3, p. 4), that the operative report for Patient A did not indicate that the Respondent inspected the portal vein for cancerous involvement (FF 4, p. 4), that the Respondent performed the Whipple Resection without removing the entire tumor in the liver (FF 4, p. 4) and that a Whipple Resection is better done at a larger medical center, rather than the small hospital at which the Respondent performed the procedure on Patient A (FF 6, p. 4). The Committee

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<sup>1</sup> Department of Family Medicine, 479 Irving Avenue, No. 200, Syracuse, New York 13210.

concluded that the Respondent had erred in performing the Whipple Resection at all, rather than referring the procedure to a larger medical center, that the Respondent erred in proceeding with the procedure upon finding a metastatic carcinoma in the patient's liver and upon determining that the portal vein involved with the carcinoma could not be resected (Conclusions p. 5). The Committee concluded that the Respondent had no indication to perform an exploratory laparotomy and a total hysterectomy on Patient B on October 8, 1988 (Conclusions, p. 7). The Committee found that the Respondent had an indication to perform a re-operation on Patient D on February 9, 1990 but that the Respondent did not perform such surgery until February 12, 1990 (FF. 6 and 7, p. 11). The Committee concluded that the Respondent had sufficient evidence of a mechanical blockage in Patient D to warrant an immediate re-operation on February 9, 1990 and the Committee concluded that nothing in Patient D's hospital record indicated that the Respondent should perform the intra-operative cystic duct cholangiogram which the Respondent performed on February 3, 1990 (Conclusions p. 12).

The Review Board believes that these findings demonstrate that the Respondent is unsafe as a surgeon and we believe that the Hearing Committee's penalty which places the Respondent on one year's probation with a monitor is wholly inadequate and inappropriate to improve the Respondent's surgical skills or to protect the public health. The Respondent has already completed a four year surgical residency and still



committed frequent and serious errors in the care of the patients involved in this case. The evidence from this hearing and the Hearing Committee's findings and conclusions indicate to the Review Board that the appropriate penalty to protect the public health is to limit the Respondent's license to prohibit him from practicing surgery.

The Review Board is unsure whether the Respondent is fit to practice general medicine other than surgery. Since there are no findings of the Committee that the Board feels would provide an indication of the Respondent's competence for the practice of general medicine, the Review Board votes to refer the Respondent to PPEP at Syracuse for an evaluation of the Respondent's skills to practice general medicine. A copy of the Respondent's PPEP Evaluation, when completed, shall be forwarded directly to the Review Board.

The Respondent's license is suspended until the Respondent completes the PPEP evaluation. If the PPEP evaluation indicates that the Respondent is competent to practice general medicine, then the Respondent's suspension is lifted and he may commence general practice with the limited license immediately. If the PPEP Evaluation indicates that the Respondent is in need of retraining, then the Respondent's license shall remain suspended, except to the extent necessary for retraining, until the Respondent has completed the course of retraining successfully. If retraining is necessary, the Respondent may do the retraining at any of the nine hospitals in the New York City Metropolitan

Region which are associated with PPEP. If the PPEP evaluation indicates that the Respondent is not competent to practice general medicine and is not a candidate for retraining, then the matter is remanded to the Review Board for a further review and determination of an appropriate penalty.

**ORDER**

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

1. The Professional Medical Conduct Hearing Committee's April 16, 1993 Determination finding Dr. Merab Boter guilty of professional misconduct is sustained.
2. The Hearing Committee's Determination staying a suspension of the Respondent's license and placing the Respondent on probation is overturned.
3. The Respondent's license is limited to prohibit the Respondent from practicing surgery.
4. The Respondent's remaining license is suspended and the Respondent is referred to the Physician Prescribed Education Program (PPEP) at Syracuse for an evaluation of the Respondent's skills to practice general medicine. The Respondent's license shall remain suspended, except to the extent necessary for retraining, until he successfully completes the evaluation and any retraining, if retraining is necessary.

5. If the PPEP evaluation indicates that the Respondent is not competent to practice medicine or is not fit for retraining, this case is remanded back to the Review Board for further review as indicated in our Determination.

**ROBERT M. BRIBER**

**WINSTON S. PRICE, M.D.**

**MARYCLAIRE B. SHERWIN**

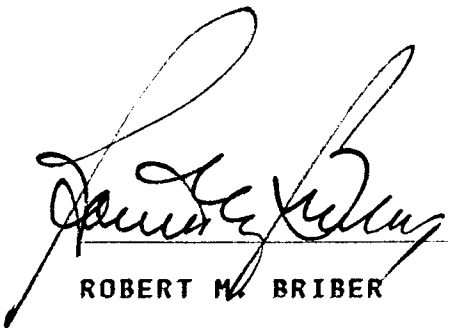
**EDWARD C. SINNOTT, M.D.**

**WILLIAM A. STEWART, M.D.**

IN THE MATTER OF MERAB BOTER, 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. Boter.

DATED: Albany, New York  
October 8, 1993



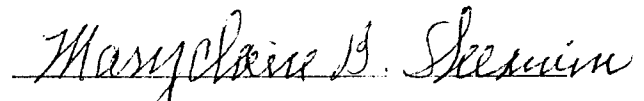
ROBERT M. BRIBER

IN THE MATTER OF MERAB BOTER, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Boter.

DATED: Albany, New York

October 8, 1993

  
MARYCLAIRE B. SHERWIN

IN THE MATTER OF MERAB BOTER, M.D.

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

DATED: Brooklyn, New York

October , 1993

  
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WINSTON S. PRICE

**IN THE MATTER OF MERAB BOTER, 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. Boter.

**DATED:** Albany, New York

October 26, 1993

A handwritten signature in cursive script, appearing to read "Edward C. Sinnott", written over a horizontal line. There is a small mark at the end of the signature that looks like "11/93".

**EDWARD C. SINNOTT, M.D.**

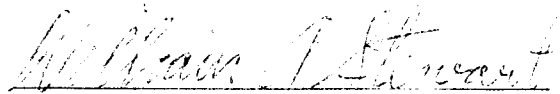


IN THE MATTER OF MERAB BOTER, M.D.

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. Boter.

DATED: Albany, New York

October , 1993

A handwritten signature in cursive script, reading "William A. Stewart", written over a horizontal line.

WILLIAM A. STEWART, M.D.