STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 21, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Clifford J. Butterman, M.D.
175 Atlantic Avenue
Oceanside, New York 11572

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann
420 Lakeville Road
Lake Success, New York 11042

David W. Smith, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Clifford J. Butterman, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-170) 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.

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.

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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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, Director
Bureau of Adjudication

TTB:cah
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTHSTATE OF NEW YORK : DEPARTMENT OF HEALTH

IN THE MATTER

OF

CLIFFORD J. BUTTERMAN, M.D.

Respondent

DETERMINATION

AND

ORDER

BPMC #02-170

COPY

A Notice of Hearing and a Statement of Charges, dated July 25, 2001, were served upon the Respondent, Clifford J. Butterman, M.D. **JAMES J. DUCEY (Chair), FLORENCE KAVALER, M.D. and RAFAEL LOPEZ, M.D.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by David W. Smith, Esq., Associate Counsel. The Respondent appeared by, Kern, Augustine, Conroy & Schoppmann, T. Lawrence Tabak, Esq. of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

PROCEDURAL HISTORY

ates of Hearing:	October 3, 2001 October 23, 2001 November 28, 2001
Date of Deliberations:	January 15, 2002

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated five categories of professional misconduct, namely, gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion and failure to maintain accurate records.

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

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving

at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Clifford J. Butterman, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about March 9, 1987, by the issuance of license number 169473 by the New York State Education Department. (Ex. 4)

2. On or about December 20, 1999, the respondent was practicing medicine at his office at 131 Main street, East Rockaway, New York. (Ex. 5)

PATIENT A

3. On or about December 20, 1999, Patient A, a female child, who was 5 years old, presented to the Respondent at his office with loose stools, vomiting, positive for URI symptoms, achy, chills and a temperature of 99.7, all other physical aspects were within normal range. When presented with those symptoms the record should contain a recording of vital signs and height and weight. It did not contain that information. (Ex. 5; T. 105)

4. On or about December 24, 1999, Patient A, a female child, who was 5 years old, once again presented to the Respondent at his office with a 9 day history of flu, vomiting, nausea, fever of 101,cough, fluids, no solids and no diarrhea. In addition there was a one week history of fever, vomiting, loose stools, cough, stuffy nose, no shortness of breath, no wheezing, tolerating fluids, not solids and a physical exam within normal limits. When

presented with those symptoms the record should contain a recording of vital signs, height and weight, a record of input and output and an abdominal examination. It did not contain that information. (Ex. 5; T. 107-8, 172-73)

5. Based on the presentation of Patient A noted above, the performance of laboratory tests on this patient were not required. (T. 147, 175-76, 423, 425-26)

6. Given Patient A's presentation on the 2 office visits, various differential diagnosis should have been entertained and ruled out. The Respondent did do this. (Ex. 5; T. 130-36, 152-53, 426-27)

7. Given Patient A's presentation and diagnosis of her medical condition, i.e. "flu," the recommendation to take motrin, clear fluids and a diet of bananas, rice, apple sauce and toast was an appropriate treatment plan. That was the treatment plan that the Respondent recommended for Patient A. The Respondent did not see Patient A again after December 24,1999. On December 26, 1999, Patient A was admitted to the hospital. (Ex. 5; T. 108, 429)

PATIENTS B and C

8. The Respondent treated Patients B and C at his office during June and July, 1998. (Exs. 12 and 15;T. 368, 386)

9. The Respondent treated Patient's B and C as their general pediatrician providing general medical care for these patients and did not treat them for apnea or bradycardia. (Exs. 12 and 15)

Conclusions

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegation was proven by a preponderance of the evidence (the paragraph noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support the Committee's conclusion:

Paragraph A.1.: (2, 3 and 4);

The Committee concluded that the following Factual Allegations were not proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support the Committee's conclusions:

Paragraph A.2.: (5);

Paragraph A.3.: (6);

Paragraph A.4.: (7);

Paragraph A.5.: (7);

Paragraph B.1.: (9);

Paragraph C.1.: (9).

The Committee further concluded that the following Specification should **be sustained:**

FAILURE TO MAINTAIN RECORDS

Fifth Specification.

The Committee further concluded that the following Specifications should **not be sustained**.

GROSS NEGLIGENCE

First Specification.

GROSS INCOMPETENCE

Second Specification.

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Third Specification.

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Fourth Specification.

FAILURE TO MAINTAIN RECORDS

Sixth and Seventh Specifications.

DISCUSSION

Respondent was charged with five 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 Committee consulted a memorandum prepared by 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 certain specified misconduct, including negligence, gross negligence, incompetence and gross incompetence in the practice of medicine. the Committee concluded, by a preponderance of the evidence, that the above delineated specifications of professional misconduct should be not sustained. The rationale for the Committee's conclusions is set forth below.

The Department presented as its expert witness to support the allegations, Dr. Jaime Fernandez. Dr. Fernandez is a board certified neonatologist. With respect to Patient A, the Committee found his testimony to be quite equivocal. On the one hand he found some of the Respondent's conduct to be professionally lacking yet he also testified that the same conduct was not a departure from accepted standards of medical care. Initially he testified that the Respondent should have considered conducting laboratory tests to assist him in developing a differential diagnoses. But upon cross-examination Dr. Fernandez testified that a failure to do those tests would not be a departure from the standard of care. He then testified under questioning by the Committee that the tests should have been "entertained."

He also testified that the respondent should have considered a number of differential

diagnoses but on cross-examination he stated that the Respondent did address a number of differential diagnosis. Dr. Fernandez did not testify at all with respect to the charges relating to other medication that the department alleged should have been prescribed nor did he testify that the Respondent failed to appropriately develop a treatment plan or monitor Patient A.

The only area wherein Dr. Fernandez was consistent was in the deficiencies he noted in the physical examination of Patient A or the lack of notation thereof. The Committee also found the Respondent's own expert witness, Dr. Simeon David, noted deficiencies in that area or the recording thereof.

It is the Department's burden to prove the elements of the allegations by a preponderance of evidence. In this case, with respect to charges A.2. through A.5. they did not meet that burden. The Department's expert witness' testimony did not confirm the elements of the charges or that the Respondent's actions in his treatment, as set forth in those charges, did not meet the standard of care. His testimony was contradictory and appeared to support both a finding of misconduct and a conclusion that the Respondent met the standard of care. Given that, the Committee could not, based on the record, conclude that those allegations noted above were proven and therefore only one specification should be sustained.

The Committee found the charges concerning Patients B and C to be unproven. These two patients were 29 week pre-term twin boys. The allegations for both these patients states that the Respondent treated them "for apnea and bradychardia." That was not the case. The Respondent saw these patients for what could be called "well baby visits." They were being

treated for apnea and bradychardia by other physicians. Given that fact, the physical conducted and noted by the Respondent was adequate and the specifications relating to these patients were not sustained.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that the **Fifth Specification should be sustained.** All of the **remaining specification are not sustained.**

The Committee also unanimously determined that the Respondent's license to practice medicine in New York should be placed on **probation for one (1) year.** The terms of the probation are set forth in Appendix II, attached hereto and made a part of this Determination and Order.

ORDER

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

1. The **Fifth Specification** of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) is **SUSTAINED**;

2. The Respondent's license to practice medicine is placed **on probation for a period of one (1) year.**

DATED: New York, New York

May 17 **, 2002**

JAMES J. DUCEY (Chair),
FLORENCE KAVALER, M.D.
RAFAEL LOPEZ, M.D.

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

IN THE MATTER

OF

CLIFFORD JAY BUTTERMAN, M.D.

STATEMENT

OF

CHARGES

CLIFFORD JAY BUTTERMAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 9, 1987, by the issuance of license number 169473 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On December 20th and 24th, 1999, Patient A, a 5-year old girl, presented to Respondent at his office with a history of diarrhea, vomiting and fever. On December 26, 1999, she was admitted to Mercy Hospital on an emergency basis, in serious condition, and transferred immediately to Winthrop University Hospital where she died on December 29, 1999.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

2. Respondent inappropriately failed to perform or cause to be

performed laboratory tests or note such tests, if any.

3. Respondent inappropriately failed to diagnose Patient A's condition correctly or note such diagnosis, if any.

4. Respondent inappropriately failed to prescribe proper medication for Patient A or note such prescribing, if any.

5. Respondent inappropriately failed to develop a treatment plan for Patient A or monitor her status or note such treatment plan or monitoring, if any.

B. During in or about June and July, 1998, Respondent treated Patient B, a 29 week pre-term male twin, for apnea and bradycardia at his office.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

C. During in or about June and July, 1998, Respondent treated Patient C, a 29 week pre-term male twin, for apnea and bradycardia at his office.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. Paragraphs A and A1-5.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. Paragraphs A and A1-5.

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

3. Paragraphs A and A1-5.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

4. Paragraphs A and A1-5.

FIFTH THROUGH SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

5. Paragraphs A and A1-5.
6. Paragraphs B and B1.
7. Paragraphs C and C1.

DATED: July 25, 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

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

3. Respondent shall submit prompt (within 20 days) written notification to the Board, addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River St., 4th Floor, Troy, New York 12180, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC 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 residency or practice outside New York State shall toll the probationary period, which shall be extended by the length of residency or practice outside New York State.

5. Respondent shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms and conditions of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

6. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

7. The Respondent shall practice medicine during the period of probation only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection no less than 10 of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

8. During the first 26 weeks of the period of probation Respondent shall work one half-

day a week, either a morning or an afternoon, in a supervised setting, limited to an institution licensed pursuant Article 28 of the Public health Law. Respondent will advise the OPMC of all such settings over the period of probation.

(b) Respondent may not practice medicine until the supervised setting is approved by OPMC. Any practice of medicine prior to the submission and approval of a proposed practice setting will be considered a violation of probation.

(c) Respondent will identify an appropriate supervisor or administrator in all settings, to be approved by the OPMC, who will submit reports regarding the Respondent's overall quality of medical practice.

(d) Respondent will provide the supervisor/administrator in all settings, a copy of the Determination and Order and Terms of Probation and will authorize said supervisor/administrator, in writing, to comply with the OPMC schedules and requests for information.

(e) Semi-annual confirmation of continued employment will be required.

(f) A supervised setting is one where an approved supervisor or administrator is always on premises when Respondent is.

9. Respondent shall take 20 credit hours per year of Continuing Medical Education courses in the subject area of medical record keeping, subject to the approval of the OPMC.

10. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.