STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

March 27, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Rosita Aquino, M.D.
63 Hillview Drive
Norwich, New York 13815

Michael S. Kelton, Esq.
Lippman, Krasnow & Kelton LLP
711 Third Avenue
New York, New York 10017

Kevin P. Donovan, Esq.
N.Y.S. Dept. of Health
Rm. 2429 Corning Tower
Empire State Plaza
Albany, New York 12237

Effective Date: 04/03/95

RE: In the Matter of Rosita Aquino, M.D.

Dear Dr. Aquino, Mr. Kelton and Mr. Donovan :

Enclosed please find the Determination and Order (No.94-270) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

ROSITA AQUINO, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-270

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on March 10, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) December 20, 1994 Determination finding Dr. Rosita Aquino (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on January 4, 1995. James F. Horan served as Administrative Officer to the Review Board. Kevin P. Donovan, Esq. filed a brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on February 8, 1995. Michael S. Kelton, Esq. filed a brief for the Respondent on February 2, 1995 and a response on February 23, 1995.

SCOPE OF REVIEW

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

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

[1]Dr. Stewart participated in the proceeding by conference call.

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

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

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

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an OB/GYN, with practicing medicine with negligence on more than one occasion, gross negligence, gross incompetence and failure to maintain adequate records. The Charges concern obstetric care which the Respondent provided during delivery for two patients, A and B. The Hearing Committee found that the Respondent was not guilty of gross incompetence in the care of Patients A and B, but found that the Respondent was guilty on the other four specification of charges.

The Committee concluded that the Respondent was guilty of negligence on more than one occasion and incompetence on more than one occasion in the treatment of Patients A and B, for failing to meet appropriate standards of care in treating the two patients and for demonstrating that she does not possess the requisite knowledge and skills to practice obstetrics. The Committee's conclusions on those charges arose from the same findings. In the treatment of Patient A, the Committee found that the Respondent a) failed to respond to signs of cephalopelvic disproportion[2], indications of fetal distress and failure of labor to progress; b) failed to respond in a timely manner to the fact that the uterine contractions and fetal heart rate were not being accurately recorded; c) failed to order a cesarean delivery in a timely manner, and d) failed to properly record observations about and treatment of Patient A. In the treatment of Patient B, the Committee found that the Respondent a) failed to examine the Patient in a timely manner; b) failed to evaluate and treat symptoms of fetal

[2]Cephalopelvic Disproportion occurs when a baby's head is too large relative to the mother's pelvis to allow vaginal delivery. Cephalopelvic Disproportion is an impediment to the process of labor (HC. Findings of Fact 18 and 19).

distress; c) failed to evaluate and treat Patient B's elevated blood pressure; d) instituted, continued and increased oxytocin after indications of fetal distress[3]; and e) failed to properly record observations and treatment of Patient B.

The Committee found that the Respondent was guilty of gross negligence in the treatment of Patient B. The Committee found that the Respondent's failure to recognize, evaluate or treat fetal distress rose to the level of egregious misconduct. The Committee also found that the Respondent's failure to review fetal monitoring strips before ordering and increasing oxytocin rose to the level of inadequate care which demonstrated a disregard for patient safety.

The Hearing Committee voted to suspend the Respondent's medical license until she successfully completes a course of retraining. The Committee ordered that the Respondent complete the Phase I Evaluation at the Physician Prescribed Educational Program (PPEP) at Syracuse. The Committee provided that if PPEP issued a negative evaluation indicating that the Respondent was not eligible for retraining, that the matter would be remanded to the Hearing Committee for new deliberations on a penalty. The Committee provided that if the Respondent completed the PPEP Evaluation successfully, that she must attend the PPEP Phase II retraining in obstetrics. The Committee provided, further, that if the Respondent and the Office of Professional Medical Conduct could not find a Phase II or equivalent retraining program, that the case should be remanded to the Hearing Committee for additional deliberations. The Committee's Determination then stated, that the Respondent would be on probation until successfully completing retraining, and for an additional two years following successful completion of retraining.

The Committee found that the Respondent was capable of learning from her errors and capable of rehabilitation. The Committee noted that the Respondent had participated in continuing medical education and taken fetal monitoring courses since 1990. The Committee also noted that there were only two negative results over a time period in which the Respondent conducted 2044 deliveries. The

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[3]Oxytocin causes uterine contractions to occur (Hearing Committee p. 15, Footnote 13), and is not appropriate if a fetus is in jeopardy and is contraindicated for proteinura or prolonged labor (HC Finding of Fact 65).

Committee also found that the Respondent showed insight into her errors and motivation not to repeat her errors.

REQUESTS FOR REVIEW

PETITIONER: The Petitioner has requested that the Review Board modify the Hearing Committee's Penalty so that a private entity (PPEP) will not decide whether the Respondent can be retrained, and so that the case will not be returned to the Hearing Committee if there is no retraining program in obstetrics available for the Respondent.

The Petitioner argues that the Hearing Committee, not a private entity, such as PPEP, should determine whether or not the Respondent can be retrained. The Petitioner notes further that the Hearing Committee has already indicated in their Determination that the Respondent was capable of learning from her mistakes, capable of rehabilitation, showed insight into her errors and motivation not to repeat her errors.

The Petitioner argues that the Review Board should amend the portion of the Hearing Committee's Determination that would return this case to the Hearing Committee if there is no retraining program in obstetrics, at PPEP or in a similar program, that would accept the Respondent. The Petitioner argues that such a remand would delay unduly the disciplinary process. The Petitioner argues that the Hearing Committee should have set out what penalty would be imposed, in the case that the Respondent could not find or complete a retraining program. The Petitioner asks that the Review Board modify the Hearing Committee's Penalty to impose a sanction against the Respondent in the event that the Respondent can not find or complete the mandated retraining in obstetrics. The Petitioner contends that an appropriate penalty in that case is to limit the Respondent's license to prohibit her from practicing obstetrics.

RESPONDENT: The Respondent contends that there was insufficient evidence before the Hearing Committee to support their findings of guilt and that the Hearing Committee's Penalty is excessive and unduly overbroad. On the findings and conclusions concerning Patient A, the Respondent argued that the evidence does not support the findings of the Hearing Committee on three of the four

allegations of negligence and incompetence which the Hearing Committee sustained. The Respondent does concede that she failed to prepare adequate notes concerning the Respondent's observations about and treatment for Patient A. On the findings and conclusions concerning Patient B, the Respondent argues that the Hearing Committee's findings do not support the five allegations of negligence and incompetence which the Committee sustained.

The Respondent argues that the Hearing Committee's Penalty is excessive, because it is not necessary to suspend the Respondent's license during the retraining period. The Respondent also argues that the penalty is overbroad. The Respondent contends that the charges against the Respondent concerned obstetrics only and there were never any allegations concerning the Respondent's practice of gynecology. The Respondent contends that the suspension of the Respondent's license would do harm to the Norwich, New York area, because the suspension would leave only one OB/GYN practicing in the area. The Respondent also contends that the Hearing Committee's Penalty is in excess of the Penalty which the Petitioner had recommended at the close of the Hearing.

In the Respondent's Reply Brief, the Respondent agrees to a limited extent, with one of the Petitioner's recommendations to the Review Board. The Respondent agrees that if the Respondent can not obtain retraining in obstetrics or is not eligible for retraining, that any limitation on the Respondent's practice should be limited to obstetrics only and not affect the Respondent's practice of gynecology.

CHENANGO HOSPITAL LETTER: Finally, the Respondent asked to submit a January 24, 1995 amicus letter to the Review Board from the President of Chenango Memorial Hospital on Dr. Aquino's behalf. The Petitioner requested that the Review Board refuse to consider the letter.

REVIEW BOARD DETERMINATION

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

The Review Board did not consider the letter from Chenango Hospital in reviewing this case.

At our deliberations on February 17, 1995, the Board granted the Petitioner's request that we refuse to consider the letter, because the letter was not part of the record before the Hearing Committee. Our Administrative Officer advised the parties of this decision by letter dated February 21, 1995.

The Review Board votes to sustain the Hearing Committee's penalty finding the Respondent guilty of negligence and incompetence on more than one occasion, gross negligence and failure to maintain adequate records. The Committee's Determination is consistent with the Committee's findings and conclusions, that the Respondent's treatment of Patients A and B did not meet appropriate standards of care and demonstrated that the Respondent does not possess the requisite knowledge and skills to practice obstetrics. The Determination is also consistent with the Committee's findings and conclusions that the Respondent's negligence in treating Patient B rose to egregious proportions and demonstrated a disregard for patient safety. The Committee's Determination is supported by their extensive findings of fact and by the record.

The Review Board votes to overrule the Hearing Committee's Penalty mandating a suspension of the Respondent's license and retraining. The Review Board votes unanimously to limit the Respondent's license to prohibit her from practicing obstetrics. The Review Board finds that the Hearing Committee's penalty is not consistent with their findings and conclusions and is not appropriate in view of the serious nature of the Respondent's misconduct in the cases of Patient A and B.

The Hearing Committee determined that the Respondent did not possess the requisite skills and knowledge to practice obstetrics and failed to meet appropriate standards of care. In the treatment of Patient B, the Committee found that the Respondent failed to recognize, evaluate or treat fetal distress and demonstrated a disregard for patient safety. The Review Board finds that these serious deficiencies cannot be corrected through retraining. An obstetrician with the experience of the Respondent should have been able to diagnose and treat in a timely manner the difficult labor and fetal distress in the cases of Patient A and B. The Respondent's disregard of patient safety is not an area which will be improved through retraining.

The Review Board limits the Respondent's license to prohibit the Respondent from practicing obstetrics. The Review Board finds that the Respondent had demonstrated through her care of

Patients A and B that she should no longer practice obstetrics. The Review Board agrees, however, with the Respondent, that there were no allegations in this case and no evidence concerning the Respondent's practice of gynecology. The Review Board finds no reason, therefore, to limit or suspend the Respondent's practice of gynecology. The Review Board feels that the prohibition of further obstetric practice by the Respondent will protect the public appropriately.

ORDER

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

1. The Review Board **SUSTAINS** the Hearing Committee on Professional Medical Conduct's December 20, 1994 Determination finding Dr. Rosita Aquino guilty of professional misconduct.

2. The Review Board **OVERRULES** the Hearing Committee's penalty suspending the Respondent's license pending evaluation and retraining at the Physician Prescribed Education Program at Syracuse.

3. The Review Board **LIMITS** the Respondent's license to prohibit her from practicing obstetrics.

ROBERT M. BRIBER
SUMNER SHAPIRO
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF ROSITA AQUINO, 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. Aquino.

DATED: Albany, New York
March 22, **1995**

ROBERT M. BRIBER

IN THE MATTER OF ROSITA AQUINO, M.D.

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

DATED: Delmar, New York

March 9, **1995**

SUMNER SHAPIRO

IN THE MATTER OF ROSITA AQUINO, 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. Aquino.

DATED: Brooklyn, New York

_____, 1995

WINSTON S. PRICE, M.D.

IN THE MATTER OF ROSITA AQUINO, 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. Aquino.

DATED: Roslyn, New York
March 21, **1995**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF ROSITA AQUINO, 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. Aquino.

DATED: Syracuse, New York
17 Mar., **1995**

William A Stewart

WILLIAM A. STEWART, M.D.