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

December 20, 1994

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin P. Donovan, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower-Room 2429
Albany, New York 12237

Carlton F. Thompson, Esq.
Levene, Gouldin & Thompson
P.O. Box F-1706
Binghamton, New York 13902-0106

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

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

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

Enclosed please find the Determination and Order (No. 94-270) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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), "(t)he 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/rlw

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw

Enclosure

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

IN THE MATTER
OF
ROSITA AQUINO, M.D.

DETERMINATION
AND
ORDER
BPMC-94-270

PRISCILLA R. LESLIE, (Chair), **THERESE G. LYNCH, M.D.** and **STEPHEN A. GETTINGER, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10)(e) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer.

The Department of Health appeared by **KEVIN P. DONOVAN, ESQ.**, Associate Counsel.

Respondent, **ROSITA AQUINO, M.D.**, appeared personally and was represented by **LEVENE, GOULDIN & THOMPSON,** by **CARLTON F. THOMPSON, ESQ.**, of counsel.

Evidence was received, witnesses were sworn or affirmed and examined. Transcripts of the proceedings were made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	May 9, 1994
Date of Service of Notice of Hearing:	May 17, 1994
Date of Statement of Charges:	May 9, 1994
Date of Service of Statement of Charges:	May 17, 1994
Answer to Statement of Charges:	None Filed
Pre-Hearing Conference Held:	June 9, 1994
Hearings Held:	July 11, 1994 July 12, 1994 October 4, 1994 October 5, 1994
Received Petitioner's Proposed, Findings of Fact, Conclusions of Law, and Recommended Penalty:	October 31, 1994
Received Respondent's Proposed, Findings of Fact and Conclusions and Memorandum:	November 1, 1994
Witnesses called by the Petitioner, Department of Health:	Harold W. Baum, M.D.
Witnesses called by the Respondent, Rosita Aquino:	Rosita Aquino, M.D. Robert S. Phillips, M.D. Frederico G. Mariona, M.D.
Deliberations Held:	November 8, 1994

STATEMENT OF CASE

This case was brought pursuant to §230 of the Public Health Law of the State of New York (hereinafter P.H.L.). Respondent, ROSITA AQUINO, M.D., (hereinafter "Respondent") is charged with eight specifications of professional misconduct as delineated in §6530 of the Education Law of the State of New York (hereinafter Education Law).

In this case, Respondent is charged with: (1) professional misconduct by reason of practicing the profession with negligence on more than one occasion[1]; (2) professional misconduct by reason of practicing the profession with incompetence on more than one occasion[2]; (3) professional misconduct by reason of practicing the profession with gross negligence[3]; (4) professional misconduct by reason of practicing the profession with gross incompetence[4]; and (5) failing to maintain records which accurately reflect the evaluation and treatment of the patients[5].

The charges concern the medical care and treatment provided by Respondent to two (2) patients (A & B)[6]. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

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[1] Education Law §6530(3) and First Specification of Petitioner's Exhibit # 1.

[2] Education Law §6530(5) and Second Specification of Petitioner's Exhibit #1.

[3] Education Law §6530(4) and Third & Fourth Specifications of Petitioner's Exhibit # 1.

[4] Education Law §6530(6) and Fifth & Sixth Specifications of Petitioner's Exhibit # 1.

[5] Education Law §6530(32) and Seventh & Eighth Specifications of Petitioner's Exhibit # 1.

[6] Patients are identified in Appendix A of the Statement of Charges, Petitioner's Exhibit # 1.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence or testimony, if any, was considered and rejected in favor of the cited evidence. Some evidence and testimony was rejected as irrelevant. Unless otherwise noted, all Findings and Conclusions herein were unanimous. The State was required to meet the burden of proof by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on August 29, 1980, by the issuance of license number 143390 by the New York State Education Department. (Petitioner's Exhibits # 1 and # 2)[7]

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. (Petitioner's Exhibits # 1 and # 2).

3. On May 17, 1994, William Cornwell personally served on Respondent: (1) a Notice of Hearing, (2) a Statement of Charges, both dated May 9, 1994, and (3) a summary of Department of Health Hearing Rules. (Petitioner's Exhibit # 1)

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[7] refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or by Rosita Aquino, M.D. (Respondent's Exhibit).

4. Harold W. Baum has been in Obstetrics and Gynecology (Ob-Gyn) practice since 1957 and was certified in Ob-Gyn Practice by the American Board of Ob-Gyn in 1961 and re-certified in 1978. Dr. Baum is experienced in Obstetrics, Gynecology, Laparoscopy, Colposcopy and Fetal Monitoring. Dr. Baum was chairman of the Ob-Gyn department at St. Luke's Memorial Hospital in New Hartford, NY and a member of the peer review committee of that hospital. (Petitioner's Exhibit # 7); [T-14-17][8]

5. Robert S. Phillips has been in Ob-Gyn practice since 1961 and was certified in Ob-Gyn Practice by the American Board of Ob-Gyn in 1966 and re-certified in 1981. Dr. Phillips has been in private practice in NY since 1961. Dr Phillips is a full clinical professor of Obstetrics and Gynecology for the SUNY Health Science Center at Syracuse. (Respondent's Exhibit # B); [T-504-508]

6. Frederico G. Mariona has been in Ob-Gyn practice since 1963 and was certified in Ob-Gyn Practice by the American Board of Ob-Gyn in 1972 and re-certified in 1991. Since 1974, Dr. Mariona has practiced high-risk obstetrics. Dr. Mariona became Board certified in maternal/fetal medicine in 1979. Dr. Mariona participated in writing ACOG guidelines for perinatal care and has made national and international presentations to medical groups. (Petitioner's Exhibit # C) and [T-606-610]

7. Rosita N. Aquino has been in Ob-Gyn practice since 1972 and was certified in Ob-Gyn Practice by the American Board of Ob-Gyn in 1977. From 1973 to 1979, Dr. Aquino was director of clinics in a Detroit, MI., maternal and infant care project, at Crittenton (Henry Ford) Hospital. Dr. Aquino has been in solo practice in

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[8] Numbers in brackets refer to transcript page numbers. [T-]

Canton, MI and in Norwich, NY since 1981. (Respondent's Exhibit # A) and [T-235-236]

Patient A

8. Patient A, a 22 year old female had an estimated date of delivery of November 27, 1990. Patient A was admitted to Chenango Memorial Hospital ("Chenango") on November 26, 1990, at 10:00 P.M. (Petitioner's Exhibit # 3); [T-22-23]

9. Patient A's physician was Dr. Maye, but the patient was admitted by and to the service of Respondent as she was covering for Dr. Maye in his absence. (Petitioner's Exhibit # 3 at 3, 9); [T-24, T-253]

10. On admission the patient's cervix was 100% effaced, 2+centimeters dilated, vertex presentation, and at -1 station with vital signs within normal limits. The fetal heart rate at this time was in the 120's. (Petitioner's Exhibit 3); [T-23-24]

11. On November 26, 1990, at 10:45 P.M. the Chenango "O.B."[9] nurse in charge, Dawn Stone, contacted Respondent and notified her of the patient's status. Nurse Stone indicated that the patient was in early labor with no particular risk factors. (Petitioner's Exhibit # 3 at 9); [T-25, T-254-258]

12. Nurse Stone was known to Dr. Aquino to be a reliable and competent nurse and Dr. Aquino had confidence in her assessments. [T-258]

13. The guidelines of the American College of Obstetricians and Gynecologists ("ACOG") grant discretion to the obstetrician as to when to arrive at

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[9] Obstetric

the hospital based on initial examination of the patient performed by qualified nursing personnel revealing early labor with no complications or contraindication. [T-76-77]

14. Chenango Hospital policy did not require the obstetrician to come to the hospital to examine the patient if the report from the examining nurse was favorable. [T-258]

15. Respondent performed a physical examination of Patient A at Chenango on the next day, November 27, 1990, at 9:27 A.M. Respondent described the fetus as long and skinny. (Petitioner's Exhibit # 3 at 14, 21); [T-79-80, T-259-265, T-518-520, T-546]

16. At 12:35 P.M. on November 27, 1990, Respondent ruptured the membranes of Patient A and it was noted that the patient's cervix was seven centimeters dilated, the fetus was in the vertex, or head first, presentation and the fetal heart rate was 120-140. (Petitioner's Exhibit # 3 at 15, 22); [T-34, T-270-271]

17. At 2:00 P.M. on November 27, 1990, patient A was fully dilated and she had started the second stage of labor. The generally acceptable length for a second stage of labor is up to two hours. When the second stage of labor lasts longer than two hours, it is referred to as prolonged second stage. (Petitioner's Exhibit # 3 at 15); [T-36, T-55-56, T-558]

18. Patient A's coccyx was very prominent, she had narrow sidewalls and when the mother pushed, the baby, who was in an occiput posterior position, would come down but would then slide back up. (Petitioner's Exhibit # 3 at 22); [T-57-58] The aforementioned observations may be signs of Cephalopelvic Disproportion which is an impediment to the progress of labor. [T-30-31, T-57-60]

19. Cephalopelvic Disproportion ("CPD") occurs when the baby's head is too large relative to the size of the mother's pelvis to allow vaginal delivery. [T-60]

20. Electronic fetal monitoring records the fetal heart rate and uterine contractions. Electronic fetal monitoring is done to evaluate the status of the baby during the course of labor. [T-42] Electronic fetal monitoring permits a physician to assess how the fetus is tolerating labor, by examining the alteration of the fetal heart rate during or after a uterine contraction, and how long it takes the fetal heart to return to the baseline. [T-42-43] An external electronic fetal monitoring was utilized with Patient A. (Petitioner's Exhibit # 3 at 71-116); [T-20-21, T-54]

21. At 3:15 P.M. on November 27, 1990, Respondent was notified of the patient's status. (Petitioner's Exhibit # 3 at 16); [T-37, T-88, T-273, T-530]

22. Fetal bradycardia[10] began at 4:00 P.M. on November 27, 1990, when there was a precipitous drop in the fetal heart rate to 90-100 beats per minute. (Petitioner's Exhibit # 3 at 16); [T-37-38, T-62, T-531] The normal fetal heart rate is 120 to 160 beats per minute. [T-40, T-349]

23. At 4:00 P.M. on November 27, 1990, oxygen was administered to the mother per Respondent's standing order. (Petitioner's Exhibit # 3 at 16); [T-38, T-62, T-275]

24. At 4:20 P.M. on November 27, 1990, Respondent was notified about decelerations in the fetal heart rate. (Petitioner's Exhibit # 3 at 16); [T-278]

25. Respondent arrived at Chenango at 4:45 P.M., on November 27, 1990. (Petitioner's Exhibit # 3 at 16); [T-41, T-532]

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[10] A slow fetal heart rate (below 120 beats per minute).

26. Further indications of fetal distress occurred on November 27, 1990, at (a) 4:15 P.M., (b) 4:20 P.M., (c) 4:25 P.M., (d) 4:40 P.M., (e) 4:50 P.M., (f) 5:00 P.M., (g) 5:10 P.M., (h) 5:20 P.M., (i) 5:30 P.M., (j) 5:35 P.M., (k) 5:45 P.M., and (l) 5:52 P.M., when there were fetal heart rates of (a) 80's, (b) 70-80, (c) 80's, (d) 80-90, (e) 80's, (f) 80-90, (g) 80-90, (h) 70-80, (i) 70-80, (j) 70's, (k) 80-110, (l) 90-110 beats per minute, respectively. (Petitioner's Exhibit # 3 at 16, 17); [T-39-40, T-48-49]

27. The above fetal heart rates are indicative of fetal bradycardia and may represent fetal distress. [T-39, T-46, T-50-51, T-349]

28. Fetal bradycardia is indicative of an impairment of the fetus's circulation and maintenance of its intrauterine environment. [T-39]

29. Fetal bradycardia may be associated with fetal acidosis[11] or fetal asphyxia[12] which can lead to brain damage to the fetus. [T-39-40, 60-61, T-68-70]

30. No change in the station of the fetus occurred between 1:10 P.M. and 4:45 P.M. No progress of labor occurred between 2:00 P.M. and 4:45 P.M. (Petitioner's Exhibit # 3); [T-41, T-55-57, T-584]

31. With signs of CPD and fetal distress and a persistent occiput posterior with failure of labor to progress, the appropriate response, according to acceptable standards of medical care, is immediate delivery of the baby. [T-51, T-62, T-120, T-139-141]

32. Delivery by cesarean section was called for by 4:40 - 4:45 P.M. on November 27, 1990. By that time, the patient had been given an adequate trial of

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[11] Actual or relative decrease of alkali in body fluids in relation to the acid content.

[12] Deprivation of oxygen in utero.

labor. [T-119-122, T-139-141, T-145-146, T-162-163, T-340, T-372]

33. Patient A was taken to the operating room for a cesarean section at 5:52 P.M. (Petitioner's Exhibit # 3 at 17). The baby was born on November 27, 1990 at 6:27 P.M. in poor condition, with severe perinatal asphyxia and acidosis, and was transported to the neonatology unit at Wilson Hospital in Binghamton, NY. (Petitioner's Exhibit # 4 at 2, 9-10, 13).

34. Under acceptable standards of medical care, Respondent did not perform a cesarean section in a timely manner. [T-63]

35. The fetal monitor strips show that the monitor strips were not accurately or adequately recording the fetal heart rate and the uterine contractions. (Petitioner's Exhibit # 3 at 71-116); [T-52, T-135, T-532]

36. Acceptable standards of care requires that an obstetrician who is presented with the failure of a fetal monitor to accurately or adequately record uterine contractions and fetal heart rate, should resort to other acceptable methods to obtain that data. [T- 52-53] Intermittent auscultation would have been an acceptable method if done in accordance with continuous time interval ACOG guidelines. [T-529] Respondent did not resort to acceptable methods to obtain accurate or adequate records of uterine contractions and fetal heart rate. (Petitioner's Exhibit # 3); [T-55]

37. From 12:35 P.M. until delivery, after 6:00 P.M., on November 27, 1990, Patient A did not have a routine labor. There is nothing in the chart (Petitioner's Exhibit # 3), written by Respondent, that indicates what the problem was, what the proposed solution was, what the treatment was going to be or what was anticipated. [T-593-595]

38. There is no indication in the patient's chart as to what Respondent's findings were in regard to cervical dilation or descent of the head. [T-595] There is no reference in the chart, prior to the cesarean section, of a diagnosis of occiput posterior position. [T-574]

39. Respondent did not adequately or properly record her observations and treatment of Patient A. [T-63-65, T-387, T-595]

Patient B

40. Patient B, a 19 year old female had an estimated date of delivery of April 21, 1987. Patient B was admitted to Chenango on April 15, 1987, at 2:50 P.M. (Petitioner's Exhibit # 5); [T-150-152]

41. Patient B was admitted to the service of Dr. Droege, a Board certified family practitioner. (Petitioner's Exhibit # 5 at 6); [T-151, T-212]

42. In 1987, Dr. Droege was a Board certified Family Practice physician who had privileges in obstetrics and pediatrics at Chenango Memorial Hospital. [T- 212, T-395, T-435]

43. On admission the patient's cervix was 100% effaced, 4 to 5 centimeters dilated; the fetus was in vertex presentation at -2 station with vital signs within normal limits. The fetal heart rate at this time was 150 beats per minute. (Petitioner's Exhibit 5 at 6); [T-151]

44. Patient B progressed in labor until she was fully dilated at 11:15 P.M. on April 15, 1987. (Petitioner's Exhibit # 5 at 3, 9); [T-169] Full dilatation means that the patient has entered the second stage of labor. [T-157]

45. After about an hour's worth of pushing and occasional decelerations of the fetal heart rate to 90-100, Dr. Droege telephoned Respondent for a consultation at 12:10 A.M. on April 16, 1987. (Petitioner's Exhibit # 5 at 3); [T-402]

46. At 12:10 A.M. on April 16, 1987, Respondent did not go to the hospital to examine the patient, but advised Dr. Droege over the phone to have the patient push more and be given oxygen. (Petitioner's Exhibit # 5 at 3); [T-403]

47. Acceptable standards of medical care require that an obstetrician examine a patient before giving an opinion on the conduct of labor. [T-162, T-209, T-220, T-477-479]

48. The labor record shows that before Respondent arrived at the hospital there were significant decelerations in the fetal heart rate. (Petitioner's Exhibit # 5 at 8, 10, 12, 14, 15); [T-165-166]

49. Fetal bradycardia began at 8:46 P.M. on April 15, 1987, when there was a precipitous drop in the fetal heart rate to below (↓) 90 beats per minute for 25-30 seconds. (Petitioner's Exhibit # 5 at 8)

50. Further episodes of fetal bradycardia occurred at (a) 9:40 P.M., (b) 10:30 P.M., (c) 11:56 P.M., (d) 11:57 P.M., (e) 11:58-9 P.M., on April 15, 1987, when fetal heart rates were (a) (↓) 90's, (b) (↓) 90-117, (c) 90's, (d) 90's-100's, (e) 80's-90's beats per minute respectively. (Petitioner's Exhibit # 5 at 9-11)

51. Fetal bradycardia continued to occur at (a) 12:01 A.M., (b) 12:35 A.M., (c) 12:36 A.M., (d) 12:37 A.M., (e) 12:38 A.M., (f) 12:39 A.M., (g) 12:40 A.M., (h) 12:43 A.M., (i) 12:57 A.M., (j) 1:02 A.M., on April 16, 1987, when fetal heart rates were (a) 70's-80's, (b) 90's-120, (c) 90-140's, (d) 90-130's, (e) 90's-118's, (f) 90's-

120's, (g) 100's-130's, (h) 110-130, (i) 90's-120's, (j) 90's-140's beats per minute respectively. (Petitioner's Exhibit # 5 at 13-15)

52. The above non-reassuring fetal heart rates may be indicative of fetal distress. [T-172-173, T-212, T-640]

53. At 1:30 - 1:40 A.M. on April 16, 1987, Respondent was again consulted by Dr. Droege regarding Patient B. Respondent arrived at Chenango at 1:55 A.M. on April 16, 1987 to examine the patient. (Petitioner's Exhibit # 5 at 3, 16, 17); [T-159-160, T-405-406]

54. When Respondent arrived at the hospital, she did not perform a physical examination of Patient B nor did she do or request a blood pressure check or a blood test to obtain a CBC and blood chemistries. Respondent's examination of the patient did not include an assessment of the fetal size or the maternal pelvis. (Petitioner's Exhibit # 5 at 26, 29); [T-160-161, T-210, T-226, T-416]

55. Respondent did evaluate the patient to determine whether a vaginal delivery could be accomplished. Respondent also "ironed out" the perineum and instructed and encouraged the patient about proper breathing and pushing techniques. [T-411-412]

56. By 2:20 A.M., April 16, 1987, the patient had been in the second stage of labor for over two and a half hours, constituting a prolonged second stage of labor. [T-169]

57. Fetal monitoring was performed and recorded on a monitoring strip during Patient B's labor. (The reasons for fetal monitoring are explained at paragraph 20) The fetal monitor strip, in this case, demonstrates delayed decelerations and lack of

baseline variability in the fetal heart rate. Delayed decelerations may be associated with fetal distress. [T-166] Lack of variability of the fetal heart rate in response to uterine contractions indicates the fetus, at that moment, is in great jeopardy . (Petitioner's Exhibit # 5 starting at 43); [T-172] ACOG guidelines call for the fetal monitor tapes to be evaluated in intervals of fifteen minutes. [T-658, T-665]

58. The fetal monitor strips, starting at 1:50 A.M., show a sinusoidal or undulating pattern for the fetus. An undulating pattern is the wave action of the fetal heart rate recording and is a sign of loss of autonomic control which may indicate fetal distress. (Petitioner's Exhibit # 5 at 89-99); [T-171-172, T-653-654]

59. The appropriate response and acceptable standards of medical care require that an obstetrician, faced with the indications of delayed decelerations, lack of variability of the fetal heart rate in response to uterine contractions and fetal distress, immediately cause delivery of the baby. [T-173, T-675]

60. By 2:00 - 2:10 A.M., on April 16, 1987, with the signs of fetal distress indicated, including delayed decelerations and lack of variability, and the prolonged labor, Respondent should have delivered the baby by cesarean section. [T-167-168, T-173]

61. On April 15, 1987, Patient B's blood pressure was recorded as 140/100 at 9:50 P.M., 150/100 at 10:15 P.M., 142/100 at 10:30 P.M. and at 10:45 P.M., and 147/85 at 11:10 P.M. On April 16, 1987, Patient B's blood pressure was recorded as 142/98 at 12:20 A.M., 146/61 at 1:09 A.M., 143/71 at 1:29 A.M., and 147/60 at 1:42 P.M. (Petitioner's Exhibit # 5 at 9-16].

62. Hypertension or high blood pressure is a blood pressure reading equal to or greater than 140/90 millimeters of mercury. [T-195, T-466] The blood pressure readings listed above indicate that Patient B had elevated blood pressures. [T-662]

63. Respondent did not review the labor records or the fetal monitor strips, but relied solely on the monitor digital readout. [T-408] It does not meet acceptable standards of medical care for an obstetrician to solely rely on digital readout and not review the labor records or the fetal monitor strips documents. [T-446, T-453, T-639, T-656-657]

64. Respondent ordered that Pitocin (Oxytocin)[13] be administered to the patient at 2:19 A.M., on April 16, 1987. Respondent then ordered that the administration of Oxytocin be increased at 2:35 A.M., 2:48 A.M., and 3:12 A.M. (Petitioner's Exhibit # 5 at 17, 34, 35).

65. Oxytocin is not an appropriate drug to use if the fetus is in jeopardy. [T-643] However, Oxytocin is not contraindicated in the presence of proteinuria or for a prolonged second stage of labor. [T-228-229]

66. In view of the signs of fetal distress, Respondent's order for administration of Oxytocin to the patient at 2:19 A.M. did not meet acceptable standards of medical care. [T-169, T-656]. The follow-up three (3) additional orders for increases in the amount of Oxytocin given to the patient also failed to meet acceptable standards of medical care required of an obstetrician. [T-170]

67. The 2+ protein level in the patient's urine sample was unreliable due to blood in the urine sample. [T-194, T-217]

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[13] A drug which causes uterine contractions to occur. [T-168]

68. Testing for hyperreflexia is an inherently subjective test. A 2+ reflex level is not unusual for a patient undergoing a difficult active labor.[T-221, T-617]

69. There is no indication in the chart as to what Respondent's findings were in regards to the fetal size and the maternal pelvis. [T-161] There is no contemporaneous recording throughout the period of time that Respondent was taking care of Patient B in Chenango, from 1:55 A.M. on. [T-647]

70. Respondent did not adequately or properly record her observations and treatment of Patient B during the course of her attendance with the patient. (Petitioner's Exhibit # 5); [T-160-161, T-175]

71. Patient B's baby was born on April 16, 1987, at 3:51 A.M., and diagnosed as having neonatal hypoxia and primary asphyxia, and was transported to Wilson Memorial Hospital, Johnson City, NY. (Petitioner's Exhibit # 6 at 2-4); [T-175-176]

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee, unless otherwise noted.

The Hearing Committee concludes that the following Factual Allegations, from the May 9, 1994, Statement of Charges, are **SUSTAINED:**[14]

Paragraph A. (first sentence)	:	(8)
Paragraph A.2	:	(8 - 34)
Paragraph A.3	:	(8 - 36)
Paragraph A.4	:	(8 - 34)
Paragraph A.5	:	(8 - 39)
Paragraph B. (first sentence)	:	(40)
Paragraph B.1	:	(40 - 47; 53-55)
Paragraph B.2	:	(40 - 60; 67)
Paragraph B.3 (in part)[15]	:	(40 - 63)
Paragraph B.4 (in part)[15]	:	(40 - 60; 64 - 67)
Paragraph B.6	:	(40 - 72)

[14] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

[15] See Discussion.

The Hearing Committee concludes that the following Factual Allegations, from the May 9, 1994 Statement of Charges, are **NOT SUSTAINED:**

Paragraph A.1	:	(8 - 31)
Paragraph B.3 (in part)[16]	:	(32 - 57)
Paragraph B.4 (in part)[16]	:	(32 - 57)
Paragraph B.5	:	(32 - 57)

Based on the above, the Hearing Committee concludes that the following Specifications of Charges are **SUSTAINED:**[17]

FIRST SPECIFICATION:	(Paragraphs: A, A.2, A.3, and A.4)
	(Paragraphs: B, B.1, B.2, B.3[18] and B.4[18])
SECOND SPECIFICATION:	(Paragraphs: A, A.2, A.3, and A.4)
	(Paragraphs: B, B.1, B.2, B.3[18] and B.4[18])
FOURTH SPECIFICATION:	(Paragraphs: B, B.1, B.2, B.3[18] and B.4[18])
SEVENTH SPECIFICATION:	(Paragraphs: A and A.5)
EIGHTH SPECIFICATION:	(Paragraphs: B and B.6)

Based on the above, the Hearing Committee concludes that the following Specifications of Charges are **NOT SUSTAINED:**

THIRD SPECIFICATION:	(Paragraphs: A, A.2, A.3 and A.4)
FIFTH SPECIFICATION:	(Paragraphs: A, A.2, A.3 and A.4)
SIXTH SPECIFICATION:	(Paragraphs: B, B.1, B.2, B.3[18] and B.4[18])

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[16] See Discussion.

[17] The citations in parentheses refer to the Factual Allegations which support each Specification.

[18] Sustained in part, see Discussion.

DISCUSSION

The Respondent is charged with eight specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However, except for the charge of failure to maintain accurate records, §6530 of the Education Law does not provide definitions or explanations of the types of misconduct charged in this matter.

The Administrative Law Judge issued instructions to the Hearing Committee regarding the definitions of medical misconduct as alleged in this proceeding. These definitions were obtained from a memorandum, prepared by Peter J. Millock, General Counsel for the New York State Department of Health, dated February 5, 1992[19]. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, (hereinafter "Misconduct Memo"), sets forth suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion and (5) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

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[19] A copy of this Memorandum was made available to both parties at the beginning of the Hearing. The cases provided by Respondent in her memorandum (pp 54-55) were also considered by the Hearing Committee.

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee (physician) 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. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct.

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. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

Medical records are not adequate unless they contain a statement of the physician's care and treatment of a patient that is accurate and sufficient in detail to convey patient information to another physician. The medical records should contain objectively meaningful medical information. Schwarz v. Regents, 89 A.D.2d 711 (3d Dept. [case 13] 1982)[20] lv. to appeal denied 57 N.Y.2d 604 (1982)

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

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[20] Petitioner's Proposed Findings of Fact, Conclusions of Law, and Recommended Penalty at P.3

The Hearing Committee was instructed by the Administrative Law Judge, to use ordinary English usage and understanding for all other terms, allegations and charges.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Harold W. Baum as the Petitioner's expert, presented an impartial and very credible approach to the documents and questions presented, with no professional association with the Respondent. On rare occasions, Dr. Baum seem to indicate that no "gray" areas existed in the practice of obstetrics, a concept rejected by the Hearing Committee.

Dr. Frederico G. Mariona as the Respondent's expert for Patient B also presented a very credible and thorough review of the documents and questions posed. Although he was professionally acquainted with the Respondent in the 1970's, his testimony was very forthright and convincing.

Both Dr. Baum and Dr. Mariona testified in a direct and forthright manner. Neither appeared to have had a stake in the outcome of these proceedings and no motive for falsification or fabrication of their testimony was alleged or shown. The Hearing Committee found Dr. Baum and Dr. Mariona to be eminently credible witnesses and gave their testimony great weight.

Dr. Robert S. Phillips as the Respondent's expert for Patient A presented somewhat credible testimony. However, in a number of areas he gave vague or insufficient responses.

The Respondent offered some credible testimony and some incredible testimony. Respondent was untruthful when necessary to bolster her position. At times Respondent's testimony conflicted with documentary evidence and defied common sense. One recurring example concerns Respondent's testimony of being with the patient continually, for at least two (2) hours, with one hand on the patient's abdomen and the other hand in the patient's vagina attempting to rotate the head. Yet at another time, Respondent stated that it was not customary for her to check the "patient every fifteen minutes vaginally. You can produce an infection in that way." [T-325] Another example concerns the reading of the monitoring strip, to wit: Respondent read the top half, but not the bottom half. In addition, Respondent's explanation of her role as an obstetric consultant, on Patient B, either was not rational or was fabricated for the circumstances.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. A great deal of Respondent's testimony was found to be mostly self-protecting and less than honest. As a result, the Hearing Committee gave little weight to Respondent's testimony, unless otherwise supported.

With regard to a finding of medical misconduct, the Hearing Committee first assessed Respondent's medical treatment and care of the patient, without regard to outcome, in a step-by-step assessment of patient situation, followed by medical responses provided by Respondent to each situation. Where medical misconduct has

been established, the outcome may be, but need not be, relevant to the imposition of penalty (if any) by the Hearing Committee. Patient harm need not be shown to establish negligence in a proceeding before the Board for Professional Medical Conduct.

Using the above definitions and understanding, including the remainder of the Misconduct Memo, the Hearing Committee unanimously concludes that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State. The Department of Health has met its burden of proof as to five (5) of the eight (8) specifications of misconduct contained in the May 9, 1994 Statement of Charges.

The Hearing Committee unanimously votes to sustain the first two (2) Charges, the fourth, seventh and eighth Charge. The Hearing Committee unanimously votes not to sustain the third charge of misconduct. The Hearing Committee votes 2 to 1 not to sustain the fifth and sixth Charge.

The rationale for the Hearing Committee's conclusions is set forth below.

I **Service of Charges and of Notice of Hearing.**

P.H.L. §230(10)(d) requires that the Charges and Notice of Hearing be served on the licensee personally, at least twenty (20) days before the Hearing. If personal service cannot be made, due diligence must be shown and certified under oath. After due diligence has been certified, then, the Charges and Notice of Hearing must be served by registered or certified mail to the licensee's last known address, at least fifteen (15) days before the Hearing.

From the affidavit submitted, personal service of the Notice of Hearing and the Statement of Charges on Respondent was proper and timely. In addition, Respondent appeared at the Hearing and had no objection to service of the Statement of Charges and the Notice of Hearing.

II Negligence on more than one occasion

In 1987, Respondent had been authorized to practice medicine in New York State for approximately 7 years. In addition, Respondent had been trained and practiced obstetrics and gynecology for at least 15 years prior to 1987. The record clearly establishes that Respondent failed to meet the appropriate standards of care with respect to Patients A and B. The Hearing Committee determines that those patients received inappropriate treatment from Respondent.

Patient A

Factual Allegation A.1: "Respondent failed to perform a complete examination of Patient A in a timely manner after her admission."

The Hearing Committee viewed this allegation as having two separate and distinct requirements. The first requirement was: whether the Respondent performed a complete or adequate examination. If she did, the second requirement was whether it was done in a timely manner.

As to the first requirement, the Hearing Committee concludes that Respondent performed an adequate obstetrical examination of Patient A. (Petitioner's Exhibit # 3 at 21 and [T-78-82 and T-518-523]) Respondent's observations are recorded at page 21 of Petitioner's Exhibit # 3 and need not be repeated. Although the fetal size was not stated in terms of pounds and ounces, the indication that the

baby appears "long and skinny" represents evidence that Respondent made an assessment and evaluation of the size of the fetus.

As to the second requirement, the Hearing Committee concludes that the examination of Patient A was done in a timely manner. [T-74-78, T-258 and T-515-517] Although in the perfect world it may be the proper procedure for Respondent to come in as soon as she was called by the O.B. nurse, at 10:45 P.M. on November 26, 1990, there was no requirement that she do so. The guidelines of the American College of Obstetricians and Gynecologists (ACOG) did not mandate immediate arrival of a physician at time of admission of the patient (or time of being informed of the admission). The ACOG guidelines provide that physicians be informed of the status of the patient in order to make present risk and further management decision. The timing of the physician's arrival to the hospital is determined by the information provided to the physician and by hospital policy.

Therefore, the Hearing Committee concludes that there is insufficient evidence to sustain this allegation.

Factual Allegation A. 2: "Respondent failed to appropriately respond to indications of cephalopelvic disproportion, indications of fetal distress, failure of labor to progress."

The medical record contains signs that cephalopelvic disproportion was present in this patient. There are numerous signs of fetal distress. The patient was fully dilated for more than four (4) hours with no progress in labor for more than 2 hours before Respondent even arrived at the hospital. Acceptable standards of medical care for an obstetrician faced with all of the above signs was to effect

immediate delivery, such as by a caesarean section. Respondent waited more than an hour after she arrived at the hospital to order a caesarean section. The Hearing Committee concludes that Respondent's actions were untimely and inappropriate. [T-56-63, T-141, T-298, T-386, T-550, T-569, T-574-575]

Therefore, this allegation is sustained.

Factual Allegation A. 3: "Respondent failed to respond in a timely manner to the fact that uterine contractions and the fetal heart rate were not being accurately recorded."

Fetal monitoring plays an important role in assessing the status of the fetus during labor. Respondent admitted that it was important to survey the well-being of the mother and fetus and record observations such as frequency, intensity, and duration of uterine contractions, but she admitted that they were not noted after she arrived at 4:45 P.M. the day of delivery. [T-346-347]

The patient records, including the monitor strips, show that the fetal monitor was not accurately recording the fetal heart rate and the uterine contractions. A reasonably trained and prudent obstetrician should take steps to obtain accurate recordings of the fetal heart rate and the uterine contractions. An alternative monitor, such as an internal electrode would have been appropriate. Respondent's use of intermittent auscultation and manual monitoring of contractions, without continuous time interval recording, was not sufficient to meet acceptable standards of medical care required of an obstetrician. [T-52-55, 134-137, T-380-381, T-532-533, T-588]

Therefore, this allegation is sustained.

Factual Allegation A. 4: "Respondent failed to order a Cesarean section delivery in a timely manner."

Respondent had sufficient signals that the fetus was not continuing to do well. Respondent admitted that the fetus had repetitive severe bradycardia which, standing alone, is an indication for cesarean delivery. Both experts (Dr. Baum and Dr. Phillips) concluded that they would have been "in there" (performing a cesarean section) sooner because there was ample cause for concern with the information available at the time that Respondent arrived at the hospital. Her delay in performing a cesarean section on Patient A failed to meet acceptable standards of medical care for an obstetrician. [T-51, T-62-63, T-115, T-119, T-141-142, T-146, T-592]

Therefore, this allegation is sustained.

Factual Allegation A. 5: "Respondent failed to properly record her observations and treatment of Patient A."

There is nothing in Patient A's medical records, written by Respondent, between 12:35 P.M. and 6:00 P.M. (Respondent returned to the hospital at 4:45 P.M.) which would indicate any problems with this patient, what the proposed solution was, what the treatment was going to be and what was anticipated. There was no objectively meaningful medical information in this patient's chart. With the problem labor that occurred to this patient, Respondent failed to adequately record her observations and treatment. There is a discrepancy regarding the correct timing of the 6:15 P.M. notes which was not adequately explained by Respondent. Respondent's credibility is also questionable on her claim of attempting to rotate the head of the fetus with her hand in Patient A's vagina for forty-five minutes, thereby being unable

to record her observations and treatment. (Petitioner's Exhibit # 3 at 22); [T-63-65, T-384-387, T-594-595]

Therefore, this allegation is sustained.

Patient B

Factual Allegation B. 1: "Respondent failed to perform a complete examination of Patient B in a timely manner after Respondent was requested to consult."

As to the first requirement[21], the Hearing Committee concludes that Respondent did not perform an adequate or complete obstetrical examination of Patient B. No blood pressure readings were requested, no blood test was requested, no assessment of the fetal size or the maternal pelvis was made. From the medical records, no examination of this patient was done by Respondent. (Petitioner's Exhibit # 5 at 26, 29); [T-479, T-660-661]

As to the second requirement[22], the Hearing Committee concludes that the "examination" of Patient B was not done in a timely manner. Once Respondent gave advice to Dr. Droege (give Oxygen and have patient continue to push) at 12:10 A.M. on April 16, 1987, Respondent established her role as a consultant. She was informed that this was a problem patient and before giving telephone medical advice should have examined the patient. The Hearing Committee does not accept Respondent's claim that Dr. Droege called merely to check where Respondent was at 12:10 A.M. [T-209, T-220, T-402-403, T-476-479] Acceptable standards of medical

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[21] See discussion of two requirements under Factual Allegation A.1, above.

[22] Since the Hearing Committee concludes that an adequate examination was not done, whether the examination was timely or not need not be addressed. However the Hearing Committee has determined to address both issues as if they were independent.

care require that an obstetrician examine the patient before giving an opinion on the conduct of labor. Respondent held herself out to be an obstetrician not merely an occiput rotator.

Therefore, this allegation is sustained.

Factual Allegation B. 2: "Respondent failed to appropriately evaluate and treat indications of fetal distress."

Respondent did not recognize, evaluate or treat the fetal distress that occurred to Patient B's fetus during the course of labor. (Petitioner's Exhibit # 5 at 8-15); [T-165-166, T-172-173, T-212, T-640, T-675]

Therefore, this allegation is sustained.

Factual Allegation B. 3: "Respondent failed to appropriately evaluate and treat Patient B's elevated blood pressure and proteinuria."

The Hearing Committee determines that there is insufficient evidence to conclude by a preponderance of the evidence that this patient had proteinuria. Therefore, that portion of the allegation is not sustained. Respondent did not recognize, evaluate or treat this patient's signs of high blood pressure. As Dr. Mariona indicated, the appropriate treatment would have been to monitor the patient's blood pressure and watch how things evolved and not just ignore it. [T-437, T-469-470, T-474-475, T-662-664]

Therefore, this allegation is sustained, in part.

Factual Allegation B. 4: "Respondent inappropriately instituted, continued and increased oxytocin after there were indications of fetal distress, proteinuria and prolonged second stage of labor."

The Hearing Committee determines that there is insufficient evidence to conclude by a preponderance of the evidence that oxytocin is contraindicated for a prolonged second stage of labor or for proteinuria. [T-228-229, T-643] Also, since the Hearing Committee did not sustain that this patient had proteinuria, (see Factual Allegation B.3 above) that portion of this allegation is not sustained.

Respondent did not recognize, evaluate or treat the fetal distress that occurred to Patient B's fetus during the course of labor. Acceptable standards of medical care requires that delivery should have been effected where evidence of prolonged labor together with fetal distress was occurring in this patient. Oxytocin is not an appropriate drug to use if the fetus is in trouble. Additional orders of oxytocin for this patient were also inappropriate and did not meet acceptable standards of medical care for an obstetrician. Respondent admitted that had she read the fetal monitor strip, she "might not" have given the oxytocin. [T-168-170, T-464, T-643, T-655-656] Accepted standards of medical practice require that a physician be or become familiar with the drugs that she prescribes, including their proper uses, side effects and under what circumstances the drugs are improper to use. A reasonably prudent physician does not prescribe drugs which are contraindicated to her patients' condition.

Therefore, this allegation is sustained, in part, to wit: as to inappropriately instituting, continuing and increasing oxytocin after there were indications of fetal distress.

Factual Allegation B. 5: "Respondent failed to request that a pediatrician be present at the time of delivery of Patient B's baby."

Chenango's practice and procedures authorized the family physician to provide care to the neonate. Patient B's family physician was Dr. Droege, who was present and had prime responsibility for providing care to Patient B's baby. Dr. Droege, who was the pediatrician selected by the patient, was present at the time of delivery, and therefore there was no need for respondent to request the presence of a pediatrician. [T-207-208, T-222, T-379, T-488-492, T-646]

Therefore, this allegation is not sustained.

Factual Allegation B. 6: "Respondent failed to properly record her observations and treatment of Patient B."

Even under abnormal labor conditions, an obstetrician does not keep her hand in the patient's vagina for two or three hours. Within that two to three hours, there had to be several opportunities to chart progress or lack thereof. Acceptable standards of medical care require that an obstetrician write notes as to the progress of labor and/or treatment plans. There was no objectively meaningful medical information in this patient's chart. Respondent did not properly record her findings or observations during the course of her attendance to this patient. [T-175, T-667]

Therefore, this allegation is sustained.

As discussed above, Respondent's care and treatment of Patients A and B were a significant deviation of acceptable standards of medical care required of an obstetrician. Respondent was negligent in her medical care of Patient A. Respondent was negligent in her medical care of Patient B.

Therefore, Respondent was negligent on more than one occasion and is guilty of professional misconduct under the laws of the State of New York.

The charge of practicing the profession with negligence on more than one occasion, within the meaning of §6530(3) and as defined by the Misconduct Memo is sustained.

III. Incompetence on more than one occasion

Respondent has shown her failure to possess the requisite skill and knowledge to practice obstetrics. Respondent's management of the care and treatment of Patient A evidenced a clear failure of the skill and knowledge expected of a practitioner in this State. In so finding, the Hearing Committee also cites the reasons set forth in ¶ II above. Respondent was incompetent in her care and treatment of Patient A when she failed to appropriately respond to clear indications of cephalopelvic disproportion, fetal distress and failure of labor to progress. When Respondent was presented with inaccurate monitor strips, she should have resorted to an acceptable method to obtain accurate information on the status of the fetal heart rate. The conclusion reached by the Hearing Committee is that either Respondent was not monitoring the fetal status or she did not know the meaning of the information she had. Either scenarios are signs of incompetence.

Respondent was incompetent in her care and treatment of Patient B when she did not recognize, evaluate or treat the fetal distress that occurred to Patient B's fetus during the course of labor. Even at the hearing, some 7 years after the incident, Respondent still thought that the fetus was doing well from 1:50 A.M. on. Furthermore, Respondent's insistence that she was only an occiput rotator and blindly

follow the family physician's orders or requests shows a lack of understanding and basic knowledge of being a consultant.

Respondent was incompetent in her medical care of Patient A. Respondent was incompetent in her medical care of Patient B.

Therefore, Respondent was incompetent on more than one occasion and is guilty of professional misconduct under the laws of the State of New York.

The charge of practicing the profession with incompetence on more than one occasion, within the meaning of §6530(5) and as defined by the Misconduct Memo is sustained.

IV. Gross Negligence

Respondent was grossly negligent in her care and treatment of Patient B and is guilty of professional misconduct under the laws of the State of New York.

The Hearing Committee determines that Respondent's failure to recognize, evaluate or treat the fetal distress that occurred to Patient B's fetus during the course of labor is egregious. There were sufficient signs of fetal distress. She should have known that fetal distress was occurring. In addition, her failure to even review the monitor strips before ordering and increasing oxytocin is sufficient to rise to a level of inadequate care which shows disregard for patient safety. Each act (B.2 & B.4) separately is sufficient for the Hearing Committee to conclude that Respondent's conduct as to Patient B was conspicuously bad and improper.

The (fourth) charge of practicing the profession with gross negligence, within the meaning of §6530(4) and as defined by the Misconduct Memo is sustained.

The (third) charge of practicing the profession with gross negligence, within the meaning of §6530(4) and as defined by the Misconduct Memo is not sustained. The Hearing Committee does not conclude that Respondent's actions as to the care and treatment of Patient A rise to the level of being grossly negligent, either singularly or cumulatively. The Hearing Committee cites the reasons set forth in ¶ II above for this conclusion.

V. Gross Incompetence

The Hearing Committee determines, by a vote of 2 to 1, that the specific type of conduct of incompetence by Respondent, as more fully and individually explained above, in ¶¶ II and III is the type of conduct which is insufficient to be considered egregious. The majority can not conclude by a preponderance of the evidence that Respondent has a total unmitigated lack of the skill or knowledge necessary to perform obstetrics. The majority does not conclude that any specific acts or cumulative acts by Respondent's tender of care and treatment to Patients A and B are of egregious nature, in the context of incompetence. The minority believes that Respondent's order of administration of Oxytocin to Patient B, when there were clear signs of fetal distress was grossly incompetent.

Respondent was not grossly incompetent in her care and treatment of Patient A and B .

The charges of practicing the profession with gross incompetence, within the meaning of §6530(6) and as defined by the Misconduct Memo are not sustained.

VI. Failure to Maintain Adequate Records

§ 6530(32) of the Education Law requires a licensee (physician) to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Respondent was charged with two counts of failing to record her observations and treatment in each of the patients' records. A review of the medical records of Patients A and B indicate a lack of information written by Respondent. (see also discussion above under ¶ II.) The crux of the problem is revealed by questioning of Respondent from the Hearing Committee, at [T-494]:

> Q. Is there anything in the chart which would indicate what the problem was, anything written by the attending doctor to indicate what the problem was, what the solution was, what the proposed solution was, what the treatment was going to be, what was anticipated?
>
> A. No, there is not.
>
> Q. Do we even know from her own examination what her findings were, as far as cervical dilatation or descent of the head?
>
> A. No, I don't see an actual note to that; correct. ...

Questions of Dr. Mariona (Respondent's expert) on this subject by the Hearing Committee: [T-666-667]

> Q. ...Is following the conduct of course of labor such an event that you'd have no time to write a note?
>
> A. Under normal conditions, usually it's not.
>
> Q. Under even abnormal conditions, does an obstetrician keep one hand in the vagina for two or three hours?
>
> A. No, he doesn't.
>
> Q. So that somewhere along the line there should be an opportunity to write a note, if one is following labor; is that correct?

A. If that's part of the obstetrician's habits and culture, indeed it is.

Q. Well, is it part of an obligation that we have to keep adequate medical records?

A. Yes.

The Hearing Committee concludes that the medical records of Patients A and B did not adequately or accurately reflect the treatment given. The medical records did not contain adequate statements of Respondent's care and treatment of Patients A or B that were in sufficient detail to convey what was occurring during labor to another physician. The Hearing Committee concludes that the medical records of Patients A and B did not adequately or accurately reflect the symptoms, diagnoses and/or progress of each patient.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, unanimously determines as follows:

1. Respondent's license to practice medicine in New York State shall be suspended[23] until she has successfully completed the retraining course(s) set forth below, and

2. Respondent must complete an evaluation and a course of retraining by attending and completing the Phase I Evaluation of the Physician's 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 at Syracuse [24]; and

3. In the event that the PPEP issues a negative evaluation, indicating that Respondent is not eligible for retraining, this matter shall be remanded to this Hearing Committee for a new deliberation as to the appropriate penalty, and

4. After successful completion of Phase I of the PPEP, Respondent must then attend and successfully complete Phase II of the PPEP [25] retraining in the area of obstetrics; and

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[23] "(W)holly, except to the limited extent required for the licensee (Respondent) to successfully complete a course of retraining;" Public Health Law §230-a (2)(b).

[24] Department of Family Medicine, 479 Irving Avenue, No. 200, Syracuse, New York, 13210.

[25] Or an equivalent program, approved by the Office of Professional Medical Conduct.

5. In the event that Respondent or the Office of Professional Medical Conduct (OPMC) can not find a Phase II or equivalent retraining program, this matter shall be remanded to this Hearing Committee for a new deliberation as to the appropriate penalty, and

6. Respondent shall be placed on probation until the successful completion of the above retraining and shall comply with the terms of probation contained in Appendix II; and

7. Respondent shall be placed on probation for a period of two (2) years after the successful completion of the above retraining ("Phase III") and shall comply with the terms of probation contained in Appendix II.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to §230-a of the P.H.L., including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The record in this case clearly establishes that Respondent committed negligence and was incompetent in the care and treatment of two of her patients. Respondent was also grossly negligent.

Respondent demonstrated deficiencies in her knowledge, skills and judgment in providing medical care to Patients A and B. Respondent also demonstrated deficiencies in her skills in maintaining adequate and accurate medical records.

However, the Hearing Committee believes that Respondent is capable of learning from her errors and is capable of rehabilitation. One positive note is the fact that Respondent has participated in two fetal monitoring courses since 1990. In addition, at least since 1990, Respondent has been involved in continuing medical education ("CME") at an average rate of 50 CME hours annually. (majority of CME courses were in Ob-Gyn, fetal monitoring and high risk pregnancies)

These factors were of particular significance to the Hearing Committee. Another mitigating factor, as to the penalty imposed by the Hearing Committee, in this case was the assertion, which was not contradicted, that the two negative results occurred over a seven year time period and Respondent has "had" 2044 deliveries in the past 12 years. Her ability in those deliveries have not been questioned.

Respondent did show some insight as to what occurred and what her deficient care was with both patients. This, as well as her motivation to not repeat her errors, is evidenced by her continual medical education course selections.

The Hearing Committee does consider Respondent's misconduct to be very serious and is concerned for the health and welfare of patients in New York State. Therefore, the Hearing Committee determines the above to be the appropriate sanctions under the circumstances.

The Hearing Committee recommends the Physician Retraining Program in this case because we believe Respondent has insight, motivation and ability.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

ORDER

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

1. The First, Second, Fourth, Seventh and Eighth Specifications of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Third, Fifth and Sixth Specifications of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in New York State is SUSPENDED (except to the limited extent required for Respondent to successfully complete a course of retraining) until she has successfully completed the retraining course(s) set forth below; and

4. Respondent must successfully complete a Phase I and a Phase II retraining as more fully discussed in this Determination and Order; and

5. In the event that Respondent is not eligible for retraining, this matter shall be remanded to this Hearing Committee for a new deliberation as to the appropriate penalty; and

6. In the event that Respondent or the Office of Professional Medical Conduct (OPMC) can not find a Phase II or equivalent retraining program, this matter shall be remanded to this Hearing Committee for a new deliberation as to the appropriate penalty; and

7. Respondent shall be immediately placed on probation until the successful completion of the above retraining and shall comply with the terms of probation contained in Appendix II; and

8. Respondent shall be placed on probation for a period of two (2) years after the successful completion of the above retraining ("Phase III") and shall comply with the terms of probation contained in Appendix II; and

9. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein; and

10. Respondent's suspension, retraining, probation and practice shall be supervised by the Office of Professional Medical Conduct; and

11. Respondent shall be required to obtain as a practice monitor a Board Certified Obstetrician acceptable to OPMC.

12. In the event that Respondent leaves New York to practice outside the State, the above periods of probation shall be tolled until the Respondent returns to practice in New York State

DATED: **Albany, New York**
December, 19, 1994

Priscilla R. Leslie

PRISCILLA R. LESLIE, (Chair),

THERESE G. LYNCH, M.D.
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APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ROSITA AQUINO, M.D.	:	CHARGES

----------X

ROSITA AQUINO, M.D., the Respondent, was authorized to practice medicine in New York State on August 29, 1980, by the issuance of license number 143390 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 January 1, 1993, through December 31, 1994, with a registration address of P.O. Box 29, Norwich, New York 13815.

FACTUAL ALLEGATIONS

A. Patient A (patients are identified in Appendix A), a 21 year old female with an expected date of confinement of November 27, 1990, was admitted to Chenengo Memorial Hospital, Norwich, New York, on November 26, 1990, in early labor. Respondent failed to appropriately manage Patient A's labor and delivery in that:

1. Respondent failed to perform a complete examination of Patient A in a timely manner after her admission.

2. Respondent failed to appropriately respond to indications of cephalopelvic disproportion, indications of fetal distress, failure of labor to progress.

3. Respondent failed to respond in a timely manner to the fact that uterine contractions and the fetal heart rate were not being accurately recorded.

4. Respondent failed to order a Cesarean section delivery in a timely manner.

5. Respondent failed to properly record her observations and treatment of Patient A.

B. Patient B, a 19 year old female with an expected date of confinement of April 21, 1987, was admitted in labor to Chenango Memorial Hospital on April 15, 1987, by another physician who sought consultation from Respondent. Respondent failed to appropriately manage Patient B's labor and delivery, in that:

1. Respondent failed to perform a complete examination of Patient B in a timely manner after Respondent was requested to consult.

2. Respondent failed to appropriately evaluate and treat indications of fetal distress.

3. Respondent failed to appropriately evaluate and treat Patient B's elevated blood pressure and proteinuria.

4. Respondent inappropriately instituted, continued, and increased oxytocin after there were indications of fetal distress, proteinuria, and prolonged second stage of labor.

5. Respondent failed to request that a pediatrician be present at the time of delivery of Patient B's baby.

6. Respondent failed to properly record her observations and treatment of Patient B.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6530(3)(McKinney Supp. 1994) [formerly N.Y. Educ. Law §6509(2)], in that Petitioner charges two or more of the following:

1. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6530(5) (McKinney Supp. 1994) [formerly N.Y. Education Law §6509(2)] in that Petitioner charges two or more of the following:

2. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

THIRD AND FOURTH SPECIFCATIONS
GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of N.Y. Educ. Law

§6530(4) (McKinney Supp. 1994) [formerly N.Y. Educ. Law §6509 (2)] in that Petitioner charges:

3. The facts of paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

4. The facts of paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

FIFTH AND SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Educ. Law §6530(6)(McKinney Supp. 1994) [formerly N.Y. Educ. Law §6509(2)], in that Petitioner charges:

5. The facts of paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

6. The facts of paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

SEVENTH AND EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

The Respondent is charged with failing to maintain a record which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law §6530(32) (McKinney Supp. 1994) [formerly N.Y. Educ. Law §6509(9) and 8 NYCRR §29.2(a)(3)], in that Petitioner charges:

7. The facts of paragraphs A and A.5.

8. The facts of paragraphs B and B.6.

DATED: Albany, New York
May 9, 1994

Peter D. Van Buren

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

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by her 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 written notification to the Board addressed to the Director, Office of Professional Medical Conduct, (hereinafter "OPMC") Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. 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 her departure and return. The probation periods shall be tolled until the Respondent returns to practice in New York State.

6. Respondent shall have quarterly meetings with an employee or designee of OPMC during the periods of probation. In these quarterly meetings, Respondent's professional performance may be reviewed by inspecting selections of office records, patient records and hospital charts.

7. Respondent shall submit semi-annual declarations, under penalty of perjury, stating whether or not there has been compliance with all terms 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.

8. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that she 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 she shall submit written proof that she has notified the New York State Education Department of that fact.

9. At Respondent's expense, Respondent shall fully participate in, cooperate with and successfully complete a three-part retraining program as a condition of probation. The retraining program shall consist of Phase I, screening examinations and evaluations conducted by the Physician Prescribed Educational Program ("PPEP"), a cooperative program of St. Joseph's Hospital Health Center and State University of New York Health Science Center, Syracuse, New York (hereinafter "Phase I") and Phase II of the Physician Retraining Program, to be completed at a participating hospital. (Or an equivalent program, approved by the OPMC (hereinafter "Phase II")

a. Respondent shall complete Phase I at the Department of Family Medicine, 475 Irving Avenue, No. 20, Syracuse, New York 13210. The Director of the PPEP shall inform the Director of the OPMC, of Respondent's satisfactory completion of Phase I and of the results of Respondent's evaluation.

b. On successful completion of Phase I, Respondent shall apply for and enroll in Phase II. Respondent shall be placed at one of the participating hospitals for completion of Phase II, a course of retraining in obstetrics and consistent with the findings made in Phase I. Respondent shall remain enrolled and shall fully participate in Phase II of the program for a period of not less than three months nor more than twelve months.

c. The elements of Phase II shall be determined by the participating institution on reviewing the findings of Phase I and the results of any evaluation provided by OPMC. The length of the Phase II program shall be determined by the Phase II preceptor assigned to the Respondent in consultation with the Director of OPMC.

d. During Phase II, the preceptor assigned to Respondent shall:

(i) Submit monthly reports to OPMC certifying that Respondent is fully participating in the Phase II program.

(ii) Report immediately to the Director of OPMC if Respondent withdraws from the program and report promptly to OPMC any significant pattern of absences by Respondent.

(iii) At the conclusion of the retraining program, submit to he Director of OPMC an assessment of the overall progress made by the Respondent toward remediation of all identified deficiencies.

e. During the 24-month period of probation beginning after completion of Phase II ("Phase III"), Respondent's practice shall be monitored by a Board Certified Obstetrician ("practice monitor") who shall be approved in advance and in writing by the OPMC. Respondent may not resume the practice of medicine (except to the limited extent required for Respondent to successfully complete a course of retraining) until an approved practice monitor

and monitoring program is in place. Any change in practice monitor must be approved, in advance and in writing, by the OPMC.

10. If there is full compliance with every term set forth herein, and the terms of the annexed Determination and Order, and, upon successful completion of the retraining period, Respondent may resume practice as a physician in New York State in accordance with these terms of probation.

11. During the length of suspension, Respondent may not practice medicine as a physician in New York State, except to the limited extent required for Respondent to successfully complete a course of retraining.

12. All expenses, including but not limited to those, of complying with these terms of probation and the Determination and Order, including retraining and monitoring, shall be the sole responsibility of the Respondent.

13. Respondent shall comply with all terms, conditions, restrictions, and penalties to which she 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 Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.

and monitoring program is in place. Any change in practice monitor must be approved, in advance and in writing, by the OPMC.

10. If there is full compliance with every term set forth herein, and the terms of the annexed Determination and Order, and, upon successful completion of the retraining period, Respondent may resume practice as a physician in New York State in accordance with these terms of probation.

11. During the length of suspension, Respondent may not practice medicine as a physician in New York State, except to the limited extent required for Respondent to successfully complete a course of retraining.

12. All expenses, including but not limited to those, of complying with these terms of probation and the Determination and Order, including retraining and monitoring, shall be the sole responsibility of the Respondent.

13. Respondent shall comply with all terms, conditions, restrictions, and penalties to which she 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 Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.