STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

March 5, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Sylvia Finkelstein, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - 6th Floor
New York, New York 10001

Glenn Gazin, Esq.
South Tower, 3rd Floor
100 Prospect Street
Stamford, Connecticut 06901

Bente Yael Hoegsberg, M.D.
Centre Road, Box 199
Strassburg, New York 12580

Richard R. Leff, Esq.
80-02 Kew Gardens Road
Kew Gardens, NewYork 11415

RE: In the Matter of Bente Yael Hoegsberg, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-46) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:lcc
Enclosure

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

IN THE MATTER

Of

BENTE YAEL HOEGSBERG, M.D.

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DETERMINATION
and
ORDER

BPMC-98-46

CAROLYN C. SNIPE, Chairperson, ROBERT J. O'CONNOR, M.D., and **DONNA B. O'HARE, M.D.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **MARILYN S. READER, ESQ.,** duly under contract with the New York State Department of Health as an Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	July 31, 1997
Statement of Charges dated:	July 31, 1997
Pre-hearing Conference:	August 15, 1997
Hearing Dates:	September 3, 1997 September 16, 1997 September 24, 1997 October 7, 1997 October 28, 1997 November 7, 1997 November 19, 1997

	November 25, 1997
Intra-hearing Conferences:	October 28, 1997 November 25, 1997
Proposed Findings of Facts received:	January 2, 1998 from OPMC January 7, 1998 from Respondent
Deliberation Date:	January 14, 1998 January 16, 1998
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001
Petitioner appeared By:	Henry M. Greenberg General Counsel NYS Department of Health By: Silvia Finkelstein, Esq. Associate Counsel
Respondent appeared in person and was represented by:	Glenn Gazin, Esq. South Tower, 3rd Floor 100 Prospect Street Stamford, Connecticut 06901 Richard R. Leff, Esq. 80-02 Kew Gardens Road Kew Gardens, New York 11415

Motions:

10/28/97 -- Offer of proof made by Respondent to introduce testimony and/or evidence relating to the presence of *Kell factors* in the blood of Baby A, and how Respondent would have changed the way she treated Patient A had Respondent been informed of the presence of *Kell factors* in Baby A's blood. Application GRANTED.

11/25/97 -- GRANTED application of OPMC to admit redacted copies of OPMC interviews of Respondent dated 7/2/96 as Exhibit 11 and dated 10/31/95 as Exhibit 12.

Review of the record by absent members of the panel: On September 16, 1997, Robert J. O'Connor, M.D., was absent from the proceedings. On November 25, 1997, Carolyn Snipe, Chairperson, was absent. They each have thoroughly reviewed the transcripts for the proceedings for which they were absent.

WITNESSES

For the Petitioner:

1. Jane M. Ponterio, M.D.

For the Respondent:

1. Bente Yael Hoegsberg, M.D., the Respondent
2. David DeIulio, M.D.
3. Frank Manning, M.D.
4. Jed Turk, M.D.
5. Jeanne Kobritz, C.N.M.
6. Ovadia Abulafia, M.D.

STATEMENT OF CHARGES

Essentially the Respondent is charged with professional misconduct by reason of:

a. Practicing the profession negligently on more than one occasion;

b. Practicing medicine incompetently on more than one occasion;

c. Practicing medicine with gross negligence;

d. Practicing medicine with gross incompetence; and

e. Failing to maintain adequate records of patients;

The Statement of Charges is annexed hereto as Appendix A.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. BENTE YAEL HOEGSBERG, M.D., the Respondent, was duly licensed to practice medicine in New York State by the issuance on September 26, 1983 of license number 155881 by the New York State Education Department. (Ex. 3).
2. The Respondent currently is registered with the New York State Education Department to practice medicine. (Ex. 3).
3. On July 9, 1997, Respondent and her counsel waived the requirement of personal service of the Notice of Hearing and Statement of Charges. (Ex. 2).
4. This proceeding was commenced by the filing of the Notice of Hearing and Statement of Charges dated July 31, 1997. (Ex. 1).
5. Respondent graduated from the University of Copenhagen Medical School in 1979. (T. 462).
6. Respondent trained for four years at the Albert Einstein Medical Center in Bronx, New York in a residency program in gynecology and obstetrics. (T. 463).

7. Respondent completed a two year fellowship in maternal fetal medicine at Brown University Program of Medicine. (T. 464). As a perinatologist Respondent is trained to manage high risk pregnancies. (T. 472).

8. Following her fellowship, Respondent joined the staff of Kings County Hospital as an attending physician and the State University of New York Downstate Medical School as an assistant professor. (T. 469).

9. From 1989 to 1990, Respondent joined the staff of Jamaica Hospital as the staff perinatologist treating service patients. (T. 471 and 473).

10. From 1990 to 1994, Respondent was a staff perinatologist at St. Luke's-Roosevelt Hospital in Manhattan, New York where she was the attending in charge of the clinical service for high risk obstetrics. (T. 473-4).

11. In 1989, Respondent was board certified in obstetrics and gynecology. (T. 472).

12. In 1994, Respondent was board certified in the subspecialty of maternal fetal medicine. (T. 472).

13. Since 1994, Respondent has been in private practice with a medical group in Poughkeepsie, New York, has attending privileges at Vassar Brothers Hospital and until 1997, was also the director of the Perinatal Diagnostic Center at Vassar Hospital. (T. 475-477).

FINDINGS OF FACT AS TO PATIENT A

14. On or about March 15, 1990, Respondent undertook the care and treatment of Patient A, a 36 year old female. At that time, Respondent was a staff attending obstetrician at Jamaica

Hospital. She ordered that Patient A be admitted to Jamaica Hospital for induction of labor with Pitocin. (Ex. 4 at 334, 335, 338, 363; and T. 41, 43, 70, 94-96, 113-115, and 1122-1123).

15. Pre-natal records of Patient A were not available to Respondent during her treatment of Patient A for labor and delivery of Baby A. (T. 1196).

16. Respondent was unaware that pre-natal records indicated Baby A had *anti-kell*, *anti-E* and *anti-C antigens.* (Ex. 4 at 2, T. 1042-1043).

17. The presence of *anti-kell, anti-C* and *anti-E antibodies* in the mother's blood increases the risk of hemolytic disease; the presence of these antigens in the fetus are strong indicators for the possible necessity of a caesarean section. (T. 1162 and 1475-1478).

18. On or about March 16, 1990, at approximately 1:40 a.m., Patient was 7 centimeters dilated and Respondent artificially ruptured Patient A's membranes. (Ex. 4 at 358; and T. 41, 43, 96 and 114).

19. Throughout labor, Patient A was monitored with an external fetal monitor and the tracings were evaluated regularly by the nurse assigned to the patient and the residents on duty, under the supervision of Respondent. (Ex. 4; and T. 1052). In the delivery room, Respondent used a Doppler to monitor the fetus. (Ex. 4 at 360; and T. 53, 55, and 1482). The signal generated was reliable. (T. 1365). Respondent appropriately monitored the fetus throughout the course of labor and delivery. (T. 1481-1482).

20. An internal fetal monitor does not show anything more than an external fetal monitor. The signal generated by the external system has an auto correlation and is easily interpreted. (T. 1465-1466, 1364-1365, and 1382-1383).

21. Patient A was fully dilated at approximately 3:20 a.m. Mild decelerations with rapid recovery and meconium staining were recorded. (Ex. 4 at 369; and T. 43-47, 51-52, 72, 88-89, 101, and 158).

22. From 3:30 p.m. on March 15, 1990 until 4:50 a.m. on March 16, 1990, Patient A was administered Pitocin in doses no greater than 20 units or 9 cc per hour. (Ex. 4 at 344-350).

23. On March 16, 1990 at 1:40 a.m. Patient A was 7 centimeters dilated and her membranes were artificially ruptured. (Ex. 4 at 358; T. 41, 43, 96 and 114).

24. Patient A continued to push until 4:50 a.m., when bradycardia was noted. (Ex. 4 at 350; T. 43-44, 51-52, 55, 72-73, 77, 88-90).

25. Respondent discontinued the Pitocin at approximately 4:50 a.m. when the bradycardic condition was noted. (T. 1148).

26. Respondent ordered Pitocin to be restarted in the delivery room. (Ex. 4 at 368; T. 55, 94-95, 1153-1155, 1159-1160, 1167-1169).

27. Suprapubic pressure was applied to assist the delivery of Patient A's baby. (Ex. 4 at 360; T. 54, 1076, 1468-1469 and 1474).

28. On March 16, 1990 at 5:32 a.m., Patient A gave birth to a stillborn infant by means of a spontaneous vaginal delivery. (Ex. 9; T. 71-72).

29. Following the delivery of a stillborn infant, Respondent manually removed the placenta and noted increased vaginal bleeding. (T. 56-63, 90-91, 108-110, 1081 and 1086).

30. Respondent manually examined Patient A's uterus at the time she removed the placenta and did not note a uterine tear. (Ex. 4 at 360; T. 1086 and 1204).

31. Vaginal bleeding continued after the placenta was removed. (Ex. 4 at 360; T. 1204).

32. Following the delivery of the baby, Respondent ordered the necessary and appropriate laboratory tests, ordered red blood cells and fresh frozen plasma, and attempted to treat Patient A's disseminated intravascular coagulation. (Ex. 4 ; T. 1472 and 1483).

33. At 6:35 a.m., approximately one hour following delivery, Patient A was given Pitocin at the rate of 9 cc's per hour. (Ex. 4 at 293).

34. At approximately between 6:50 a.m. and 7:30 a.m. Patient A had a pulse of 105, her blood pressure was intermittently present and difficult to palpate, and she had seizures. (Ex. 4 at 293-294, 361 and 371).

35. At approximately 7 a.m., Patient A was transferred to the intensive care unit ("ICU"). (Ex. 4 at 364).

36. Between 7 a.m. and until approximately 9:30 a.m., Patient A's uterus was examined by Respondent, Dr. Abitol and the resident on duty and not one of them detected the presence of a uterine rupture. (T. 1101, 1203 and 1213).

37. At approximately 9:30 a.m., the resident on duty, during an examination of Patient A's uterus, discovered a 15 centimeter tear of the lower uterine segment. (Ex. 4 at 364-365; T. 63-64 1159, 1215, and 1472).

38. Approximately four hours after delivery, Dr. Abitol, the chairman of the department, performed a subtotal hysterectomy, bilateral salpingectomy and oophorectomy. (Ex. 4 at 366; T. 1192-1994).

39. An estimated 1,000 cubic centimeters of blood was found in the pelvic cavity. The total estimated blood loss was 10 liters. (Ex. 4 at 366; T. 69 and 133-135).

40. Patient A died on March 27, 1990. (Ex. 9; and T. 69-71).

41. An autopsy determined the cause of death was disseminated intravascular coagulation ("DIC") with renal failure, ruptured uterus, prolonged delivery with oxytocin induction and therapeutic complications. (Ex. 9; T. 70-71, 1117-1118 and 1169-1170).

CONCLUSIONS AS TO PATIENT A

In Allegation A.1(a), it is stated Respondent failed to monitor the fetus appropriately. An external fetal monitor was used throughout labor, which transmitted a reliable signal throughout the labor. After Patient A was moved to the delivery room a Doppler was used to monitor the fetal heart rate. Respondent, the nurses, and the residents on duty who were treating Patient A regularly reviewed the tracings reported by the monitors. Internal monitoring does not show anything more than an external monitor. The external monitor generates a signal with auto correlation that is easily interpretable. As long as the medical team gets a reliable record, there is no advantage to either internal or external monitors. When bradycardia was noted, Patient A was promptly placed in the Trendelenburg position to elevate her feet above her head and given oxygen. Respondent appropriately monitored the fetus throughout labor and delivery.

Therefore, Allegation A.1 (a) is not sustained.

In Allegations A.1(b), (c), (d), and (e) Respondent is charged with (b) failing to expeditiously deliver Patient A via caesarean section, (c) failing to prepare and/or order that Patient A be prepared for an immediate caesarean section, (d) failing to arrange for an operating room to be prepared on

an emergent basis for immediate caesarean section and (e) failing to call for an anesthesiologist. The Committee finds Respondent appropriately managed the course of labor and delivery of Patient A and therefore preparations for a caesarean section were not medically necessary on the information provided to Respondent.

Therefore, Allegations A.1(b), (c), (d) and (e) are not sustained.

In Allegation A.1(f), Respondent is charged with inappropriately applying fundal pressure during the course of delivery. The Committee finds the opinion of Dr. Jane Ponterio that fundal pressure was applied is speculation which is not supported by the medical record. To assist Patient A's delivery, suprapubic pressure was applied in the delivery room.

Therefore, Allegation A.1(f) is not sustained.

In Allegation A.1(g), Respondent is charged with failing to monitor the fetus appropriately in the delivery room. Respondent and her medical team appropriately used a Doppler to monitor the fetus in the delivery room.

Therefore, Allegation A.1(g) is not sustained.

In Allegation A.1(h), Respondent is charged with inappropriately acting in response to the critical nature of Patient A's condition prior to and subsequent to the stillborn delivery. The Committee finds there was no critical condition prior to delivery of the baby. Following the delivery of the baby, Respondent appreciated the critical nature of Patient A's condition. Respondent appropriately ordered laboratory tests and appropriately attempted to treat Patient A's disseminated

intravascular coagulation. Respondent, Dr. Abitol, the chairman of OB-GYN, and residents on duty, at various times, manually examined Patient A's uterus. Respondent appropriately transferred Patient A to the ICU because of her critical condition. Upon discovering a lower segment tear, Respondent, Dr. Abitol and the medical team promptly prepared Patient A for surgery to repair the tear.

Therefore, Allegation A.1(h) is not sustained.

In Allegation A.1(i), Respondent is charged with having failed to document post partum uterine exploration. The medical chart documents post partum uterine explorations by Respondent, Dr. Abitol and the resident on duty. The resident recorded a uterine examination at 7:00 a.m. by Respondent, Dr. Abitol and the resident. Another uterine examination was recorded at 9:30 a.m., at which time a 15 centimeter tear was noted. The Committee notes that two Board certified obstetricians and a resident doctor examined Patient A prior to 9:30 a.m. and failed to discover the laceration. The Committee is concerned as to the adequacy of the examinations that missed a 15 centimeter tear of the lower uterine segment that eventually at 9:30 a.m. was identified during a uterine exploration of Patient A in the ICU by the resident doctor. However, examinations were documented in the medical record.

Therefore, Allegation A.1(i) is not sustained.

In Allegation A.1(j), Respondent is charged with failing to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitor tracings. Respondent regularly reviewed and appropriately interpreted the fetal heart monitor tracings through the course

of labor.

Therefore, Allegation A.1(j) is not sustained.

In Allegation A.1(k), Respondent is charged with failing to appreciate and/or demonstrate knowledge of the indications for caesarean section. As there were no indications for a caesarean section, Respondent properly followed a medical plan for vaginal delivery of Patient A's baby.

Therefore, Allegation A.1(k) is not sustained.

In Allegation A.1 (l), Respondent is charged with failing to insure that necessary post partum laboratory tests were done expeditiously. Respondent appropriately and expeditiously ordered laboratory tests to treat Patient A's condition post partum.

Therefore, Allegation A.1(l) is not sustained.

In Allegation A.1(m), Respondent is charged with failing to maintain a hospital record for Patient A which accurately reflects the condition of the patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery. During the course of treating Patient A, appropriate notes were recorded by the resident doctors and nurses, which were regularly reviewed, discussed with and at times countersigned by Respondent. As the attending physician in a teaching hospital, Respondent may rely on the notations of the medical team under her supervision, especially when the events are discussed with and reviewed by Respondent, as comprising the record of treatment Respondent and her residents provided. The Committee notes it is better practice to at least regularly countersign the residents' notes which document the course of treatment.

However, the medical record of Patient A is sufficient to enable a subsequent physician to understand and reconstruct what occurred throughout the treatment of Patient A.

Therefore, Allegation A.1(m) is not sustained.

FINDINGS OF FACT AS TO PATIENT B

42. On or about March 18, 1990, Respondent, a staff attending obstetrician, undertook the care and treatment of Patient B, a 20 year old female in active labor who was admitted to Jamaica Hospital. (Ex. 5; T. 123-124).

43. At 5:10 a.m., Respondent used vacuum extraction and Simpson forceps to deliver the baby. (Ex. 5 at 32 and 35; T 124-126, 762-763 and 775-776).

44. Respondent intentionally cut a 4th degree episiotomy on Patient B. (Ex. 5 at 35; T. 127-130, 144, and 754).

45. Respondent's 24 hour shift as the attending physician for the service ended at 8:00 a.m. on March 18, 1990. It was the policy of Jamaica Hospital that a staff attending was responsible for patient care only when on duty. (T. 755).

46. At the time Respondent's shift ended, Patient B was stable. (T. 151 and 755).

47. There was no evidence of bleeding at the time Respondent's shift ended and Respondent left the hospital. (T. 151 and 755).

48. Bleeding was noted at 1:30 p.m. and appropriate action was taken by the physicians then on duty. (T. 155).

CONCLUSIONS AS TO PATIENT B

In Allegation B.1(a), (b) and (c), Respondent is charged with (a) failing to expeditiously address Patient B's post partum hemorrhage, (b) failing to locate and repair the vaginal laceration secondary to the instrumented delivery within a reasonable period of time, and (c) failing to appropriately act in response to Patient B's emergent condition post-delivery. Respondent appropriately attended Patient B's labor and delivery. The hemorrhaging was first noted five hours after Respondent was off duty. Under the coverage policy of Jamaica Hospital, it was the responsibility of the attending physician then on duty and not the responsibility of Respondent to locate the source of bleeding and repair the damage.

Therefore, Allegations B.1(a), (b) and (c) are not sustained.

FINDINGS OF FACT AS TO PATIENT C

49. On June 18, 1992, Respondent was a staff perinatologist and attending obstetrician at St. Luke's/Roosevelt Medical Center and undertook the care and treatment of Patient C, a 42 year old female, at 34 weeks gestation. (Ex. 6B at 11-13; T. 472, 791 and 800).

50. Patient C was admitted at 5:40 p.m. (Ex. 6B at 11-12; T. 206-207 and 814-815).

51. From a prior sonogram performed on 4/28/92, Respondent knew that at 25 weeks gestation Patient C had a complete placenta previa. (Ex. 6B at 11-13 and 114; T.803). This information is noted in an admission note countersigned by Respondent. (Ex. 6B at 12; T. 803-804).

52. Patient C also had a history of alcoholism, hypertension, two previous laparotomies, a prior caesarean section for a preterm fetus for placenta previa, pancreatitis, a ruptured bladder and a fractured pelvis from a motor vehicle accident in 1981. (Ex. 6B at 11; T. 804-808).

53. At the time of admission, Patient C was stable and not actively bleeding. (Ex. 6B at 11-13 and 114; T. 816). At approximately 6:40 p.m., a nurse reported "heavy bleeding per vagina noted with a heavy sneeze -- stopped." (Ex. 6B at 13; and T. 813-815). None of the medical team treating Patient C noted persistent active bleeding. (T. 227, 806-807, 1541, 1554-1555, 1564-1565, 1569, 1572-1573.)

54. In the emergency room, Patient C was promptly and appropriately treated by Respondent and her medical team. At 5:45 p.m., Patient C was given dexamethasone; at 6:15 p.m., she was administered terbutaline; blood was ordered and the staff was waiting for a cross match; an intra-venous ("IV") line was inserted, a second IV was placed by an anaesthesiologist and the operating room was prepared for Patient C's surgery. (Ex. 6B at 13-14; T. 826).

55. Two hours after admission, Patient C continued to be stable. (Ex. 6B at 289).

56. Patient C was monitored prior to her delivery with an electronic fetal heart monitor. (Ex. 6B at 13 and 242; and T. 828).

57. A caesarean section was performed at 7:40 p.m. Respondent did not scrub in but was present in the operating room when a third year resident began the procedure with a low

transverse uterine incision approved by Respondent. (T. 208-210). The placenta was removed piecemeal. (T. 845 and 986).

58. Given Patient C's history of prior caesarean sections and abdominal surgery for a ruptured bladder, the fetus' position on a transverse lie and the known complete placenta previa, it was inappropriate to attempt a caesarean section with a transverse incision. (T. 232 and 242-243). One of the risks inherent with placenta previa is the possibility of heavy bleeding and abnormal presentment in future pregnancies. (T. 269-270 and 804).

59. The residents had difficulty delivering the baby through this incision and Respondent scrubbed in to extend the incision in the "T" manner to effect entry into the uterus through a classical incision. During efforts to deliver the baby, Respondent and the residents found the uterus to be very dense and thick. (Ex. 6B at 15, 290 and 293; T. 210, 212, 267-269, and 838-840).

60. At 8:09 p.m., Respondent delivered a live female infant, which was ascribed an Apgar score of 1-5-7. (Ex. 6B at 246; T. 214).

61. Patient C had more than normal bleeding post delivery. The residents called Respondent to the OR because they were not comfortable closing Patient C with that amount of bleeding. Patient C was reopened to explore for bleeders. Bleeding persisted. At 10:05 p.m., Respondent determined to remove Patient C's uterus and at approximately 10:45 p.m., the hysterectomy was completed. (Ex. 6B at 291; T. 850-854).

62. After the hysterectomy, bleeding still persisted. Four hours after delivery, after the hysterectomy and after continued efforts to stop the bleeding with suturing, bleeding persisted. Close to midnight Respondent and the residents identified persistent bleeding

from the right adnexa and attempts to clamp, ligate and tie this bleeder were not successful. (Ex. 6B at 291; T. 853-854 and 947).

63. Patient C had an estimated blood loss of 8,000 cubic centimeters. (Ex. 6B at 291; T. 947 and 1580).

64. While the residents were operating on Patient C post delivery, Respondent was not always in the operating room ("OR") as Respondent left the OR to attend to other patients on the labor floor. (T. 840-841).

65. Close to midnight another patient in fetal distress required immediate attention of a physician on duty. (T. 855) Although Respondent could have sent the chief resident to attend to this other patient, Respondent opted to call another attending from home to come in to the hospital to assist the chief resident and third year resident in their efforts to control Patient C's elusive bleeding from the adnexa. (T. 855, 931, 967-968, 981-982 and 998-999). Expecting the other attending to arrive within 20 minutes, Respondent left the chief resident and third year resident unsupervised to continue operating on Patient C while Respondent went to operate on the other patient with another resident. (T. 855 and 859).

66. Upon arriving at the hospital, the substituting attending physician continued the operation to stanch the bleeding of patient C. A right salpingo-oophorectomy was performed removing the right ovary and adnexa. Surgery was completed on June 19, 1992 at 1:45 a.m. (Ex. 6B at 291-292; T. 212-214, 906 and 931).

67. Respondent testified that if, while operating on Patient C for her delivery and the post partum bleeding surgery, another emergency had presented which required an attending physician, Respondent would have sent the chief resident out to stand in for her for that

procedure, while she would have stayed if she felt at the time that her presence was needed in the OR. (T. 967).

68. Respondent admits it would have been possible to send the chief resident to attend to the new patient so as to enable herself to stay with the surgery of Patient C, provide continuity of care, and complete the procedures which had already taken approximately 4 hours. In explanation of the reasons she opted to leave the OR to attend to the new patient, Respondent states, "I judged that it was better to leave him in there for several reasons. This was his case, basically. I mean, he was the main person ... in charge, and for me it was important that he was there from the beginning to the finish, because he was going to be out on his own in a few days, so ... to interrupt, pull him out and say, you go do this case, was really not, I think, a reasonable thing to do." (T. 981-982).

69. Respondent called another attending physician in to assist and supervise the residents operating on Patient C as she "felt more comfortable this time because it seemed like this was an elusive bleeder, and we had looked for it for some time, and I just felt that either I should be there or the other attending." (T. 931 and 998) Respondent felt that because of the circumstances in the OR, the residents should not be left alone to address the situation without having an attending present. (T. 999).

CONCLUSIONS AS TO PATIENT C

In Allegation C.1(a), Respondent is charged with failing to recognize and adequately manage Patient C's high risk intrapartum course. Respondent knew from the medical record and

history that a sonogram showed Patient C at 25 weeks gestation had a complete placenta previa. In addition, Respondent knew Patient C had a history of a prior caesarean delivery for a preterm baby due to placenta previa, prior abdominal surgeries for a ruptured bladder and fractured pelvis, pancreatitis, acute alcoholism, and hypertension. Respondent discussed the surgery with the residents and approved the inappropriate plan to deliver Patient C by caesarean section with a transverse incision. A transverse incision was contraindicated for Patient C who had a complete placenta previa. The risks inherent in inappropriately using a transverse incision on a patient such as Patient C with a complete placenta previa were compounded by her medical history which made her a high risk maternity patient.

Therefore, Allegation C.1(a) is sustained.

In Allegation C.1(b), Respondent is charged with failing to perform an immediate delivery via caesarean section in the presence of active bleeding on admission and known placenta previa. During the course of evaluating Patient C on admission, none of the medical personnel noted persistent active bleeding. The Committee notes that although there was a single observation by a nurse at 6:40 p.m. of "heavy bleed per vagina noted with a sneeze--stopped," no other notes indicate active bleeding while Patient C was in the emergency room. Patient C was noted to be stable from her admission to the emergency room to the time surgery commenced to deliver the baby by caesarean section. The Committee finds Patient C was not actively bleeding when she came to the emergency room nor at any time prior to delivery of the baby. Timely and appropriate measures were taken in preparation for a planned caesarean section of a high risk patient.

Therefore, Allegation C.1(b) is not sustained.

In Allegations C.1(c), (d) and (e), Respondent is charged with (c) failing to adequately supervise the residents left to perform a complicated and high risk surgical procedure, (d) failing to adequately assist the residents in the surgery of this patient with massive intra-operative hemorrhage, and (e) not appropriately acting in response to the complications that arose during the surgery. Several surgical procedures were performed on Patient C: caesarean section, a hysterectomy, explorations to locate the sources of bleeding after delivery and again, after the hysterectomy, and a salpingo-oophorectomy. The Committee defines the surgery from beginning the caesarean section to completion of the salpingo-oophorectomy and all procedures necessary to address the bleeding complications. Respondent inappropriately approved a transverse incision to effect the caesarean delivery of Patient C's baby. Further, following delivery of the baby, Patient C had bleeding complications which required identification and correction. Respondent felt the circumstances confronting the residents operating on Patient C warranted the presence of an attending in the OR to assist and supervise the residents to locate and stanch the elusive bleeders. However, rather than send the chief resident to attend to the emergency of another patient so that Respondent could continue to manage Patient C's difficult situation and assist and supervise the third year resident, Respondent opted to leave the residents, alone and unsupervised, to address these complicating factors. Although, Respondent recognized the residents were unable to manage the complications of Patient C's bleeding, Respondent improperly left the OR to attend to another patient requiring emergency surgery. Respondent improperly placed what Respondent perceived as the interests of the chief resident above the critical needs of Patient C. The Committee finds it was improper to leave the residents to continue to operate alone on Patient C without an assisting and/or supervising attending even for a period no longer than twenty minutes.

Therefore, Allegations C.1(c), (d) and (e) are sustained.

In Allegation C.1 (f), Respondent is charged with failing to timely call for a maternal fetal specialist consultation. Respondent had completed her training as a perinatologist and was employed by St. Luke's/Roosevelt Medical Center as a perinatologist. As Respondent is a specialist in maternal fetal medicine it was unnecessary for her to consult with another one.

Therefore, Allegation C.1(f) is not sustained.

In Allegation C.1(g), Respondent is charged with failing to maintain a hospital record for Patient C which accurately reflects the condition of the patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery. As noted *supra*, as the attending physician in a teaching hospital, Respondent may rely on the notations of the medical team under her supervision, especially when the events are discussed with and reviewed by Respondent, as comprising the record of treatment Respondent and her residents provided. The medical record contains appropriate notes written by the nurses and residents, some countersigned by Respondent, which adequately and sufficiently describe what occurred such that a subsequent physician can understand and reconstruct what occurred throughout the treatment of Patient C.

Therefore, Allegation C.1(g) is not sustained.

FINDINGS OF FACT AS TO PATIENT D

70. On or about October 1, 1993, Respondent was an attending obstetrician and staff perinatologist at St. Luke's/Roosevelt Medical Center and undertook the care and treatment of Patient D, a 28 year old female at 41 weeks gestation. (Ex. 7; T. 296-297 and 631).

71. Patient D was admitted at 3:29 a.m. in early active labor as a midwifery patient. (T. 632 and 647). Beginning at approximately 3:39 a.m., an external fetal heart monitor was used to continuously monitor the fetal heart rate. (T. 642 and 693-694).

72. At 8:25 a.m., Respondent was at home at 102nd Street and Fifth Avenue in Manhattan (T.674-675) when Respondent was notified by a nurse midwife of the status of Patient D. (T. 633).

73. At approximately 9:00 a.m., Respondent arrived at the hospital and was on the labor floor of the Midwifery Service. (Ex. 7 at 106; T. 634).

74. Respondent reviewed the fetal heart monitor tracings for Patient D and observed they were reassuring. (T. 648, 693). She found the tracings showed variable decelerations with contractions and good return to baseline with good reactivity. (Ex. 7 at 7-49 and 106; T. 635-636 and 1362).

75. Fetal heart monitor tracings have to be reviewed in their total context, not in isolation of any particular deceleration, but the whole pattern. The status of the fetus is measured by the presence of a normal baseline, presence of normal long term variability, oscillation in long term variability between periods of increased variability and diminished variability. (T. 1362, 1380, 1383 and 1403).

76. There was no need for an internal monitor, as the external monitor provided continuous tracings of good quality. (T. 639, 1365 and 1383).

77. Since the tracings were reassuring, there was no indication to measure the scalp pH to further assess the condition of the fetus. (T. 650, 725, 1358-1362).

78. It is appropriate for a physician reviewing a fetal heart rate tracing to record her findings only when a sinister change occurs. (T. 1363-1364).

79. At 9:20 a.m., Respondent evaluated Patient D. As the fetal heart rate tracing was reassuring, Patient D was leaking clear fluid and her pelvis seemed adequate for a 9-pound baby, Respondent appropriately formulated a plan to continue observation of Patient D. (T. 647).

80. A caesarean section was not indicated during the course of treating Patient D. (T. 1361 and 1381).

81. The indications for the use of forceps are the same as for the use of a vacuum to assist delivery. (T. 353-354).

82. Patient D was at +2 station when the vacuum was applied and the baby extracted. (Ex. 7 at 50; T. 352-353).

83. Applying a vacuum at +2 station is equivalent to a low forceps delivery. (T. 350 and 352).

84. At 12:45 p.m., Respondent delivered Patient D's baby with vacuum extraction. (T. 649-650 and 653). Thick meconium was noted at the time of delivery. (T. 304-306 and 701-703).

85. The placenta was delivered at 12:55 p.m. (T. 313 and 650).

86. After delivery of the placenta, Respondent repaired a 4th degree episiotomy. (Ex. 7 at 50; T. 735). This repair took approximately 45 minutes. While doing the repair of the

episiotomy, a sulcus tear was discovered. (Ex. 7 at 50; T. 649, 714 and 740).

87. An anaesthesiologist was promptly called, Patient D was brought to the OR at approximately 1:55 p.m., an anaesthesiologist came at approximately 2:10 p.m., and repair of the sulcus tear commenced at approximately 2:25 p.m. (Ex. 7 at 50-51 and 100; T. 668-669).

CONCLUSIONS AS TO PATIENT D

In Allegations D.1(a), (b), (c) and (e), Respondent is charged with (a) failing to respond within a reasonable time after being advised of the presence of fetal distress, (b) not properly assessing the condition of the fetus, (c) failing to perform a fetal scalp blood pH test, and (d) failing to order an internal scalp electrode monitor. Patient D's fetus was not in fetal distress. Respondent properly assessed the fetus as not in distress or jeopardy. The external fetal monitor tracings were continuous and easy to read. Neither fetal scalp blood pH testing nor use of an internal scalp electrode monitor was medically warranted because of the reassuring condition of the fetus and the good quality of tracings transmitted by the fetal heart monitor.

Therefore, Allegations D.1(a), (b), (c) and (d) are not sustained.

In Allegations D.1(e), (f) and (h), Respondent is charged with (e) not appropriately interpreting the fetal heart rate monitor tracings and/or recognizing the indication of progressive fetal hypoxia, (f) failing to recognize the presence of late decelerations with slow return to baseline, an ominous sign of fetal distress, and (h) failing to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitor tracings. The Committee accepts the

approach to interpreting fetal heart rate tracings explained by Dr. Manning, an expert witness for Respondent. Fetal heart monitor tracings have to be reviewed in their total context. A particular deceleration in isolation is not meaningful. The whole pattern of the tracing has to be viewed for the presence of a normal baseline, normal long term variability, oscillation in long term variability between periods of increased variability and diminished variability. The fetal heart rate tracings for Patient D were reassuring and Respondent properly and accurately interpreted them. There was no evidence of progressive fetal hypoxia and Respondent properly assessed there was no fetal distress. **Therefore, Allegations D.1(e), (f) and (h) are not sustained.**

In Allegations D.1(g) and (i), Respondent is charged with (g) failing to perform an immediate delivery via caesarean section and (i) failing to appreciate and/or demonstrate knowledge of the indications for caesarean delivery. A caesarean delivery was not indicated for Patient D. **Therefore, Allegations D.1(g) and (i) are not sustained.**

In Allegations D.1(j), (k) and (l), Respondent is charged with (j) failing to appreciate and/or demonstrate knowledge of the indications for forceps delivery, (k) failing to appropriately perform a forceps delivery, and (l) inappropriately performing a mid-forceps delivery rather than a low forceps delivery. Forceps were not employed. As the indications for use of forceps and vacuum are the same, the Committee reads these charges as applying to the use of the vacuum to assist delivery. The Committee finds that Respondent properly applied the vacuum at a +2 station to execute a low forceps delivery.

Therefore, Allegations D.1 (j), (k), and (l) are not sustained.

In Allegation D.1(m), Respondent is charged with failing to appropriately assess Patient D post partum. The Committee notes that the sulcus tear was identified during the repair of the episiotomy and a decision was made immediately to repair the sulcus tear under anaesthesia in an operating room. Repair of the episiotomy was completed at about 1:30 p.m. Patient D was brought to the operating room at approximately 2:00 p.m. Anaesthesia was commenced at approximately 2:15 p.m. Forty-five minutes to prepare for surgery to repair a sulcus tear is not excessive.

Therefore, Allegation D.1(m) is not sustained.

In Allegation D.2(n), Respondent is charged with failing to maintain a hospital record for Patient D which accurately reflects the condition of the Patient, the condition of the fetus, the procedures performed and the timings thereof. The midwife, nurses, residents and Respondent collectively made extensive notations of events and findings during the course of labor and delivery. Together with the record of the tracings, the hospital record provides adequate and sufficient detail such that a subsequent physician could understand and reconstruct the treatment Patient D received during the course of labor and delivery.

Therefore, Allegation D.1(n) is not sustained.

FINDING OF FACTS AS TO PATIENT E

88. On or about January 10, 1995, Respondent, a staff attending obstetrician at Vassar Brothers Hospital, undertook the care and treatment of Patient E, a 34 year old female at full term gestation. Patient E was a private patient of Respondent's group practice (Ex. 8 and T. 489).

89. Patient E was admitted by telephone to Vassar Hospital on January 10, 1995, at approximately 5:30 a.m., by one of Respondent's colleagues. (T. 490).

90. Respondent's shift as the attending obstetrician began at 8:00 a.m., at which time Respondent first met with Patient E. (T. 490).

91. Beginning at 5:31 a.m., the fetal heart rate was measured by means of an external monitor. (Ex. 8 at 200-355; T. 1383 and 1393).

92. At 10:00 a.m. Patient E was examined by Respondent who noted Patient E had contractions 5 to 6 minutes apart, was 2 centimeters dilated, 90 percent effaced. (Ex. 8 at 13; T. 493). Respondent ruptured Patient E's membranes and started administering antibiotics because Patient E was a beta strep carrier. (Ex. 8 at 249, 59 [818][1]; T. 493) When Respondent ruptured the membranes, a clear, odorless fluid was expelled. (Ex. 8 at 59 [818]; T. 493, 499 and 503).

93. At approximately 12:00 p.m., an internal scalp electrode was applied. (Ex. 8 at 263; T. 391 and 509). Respondent testifies this was done to address Respondent's uncertainty whether an apparent flatter heart rate tracing was due to a sleeping fetus, hypoxemia or other possible causes. (Ex. 8 at 22 [786], 263; T. 391 and 535-536).

94. There was no need for continuous internal scalp electrode monitor since the fetal heart monitor provided a continuous heart rate tracing. (T. 1383)

95. A caesarean section was not indicated for Patient E. It would be inappropriate to do a caesarean section just for maternal fever. (T. 1382 and 1395).

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[1] Exhibit 8 was submitted in triplicate copy. The first set is numbered 1 to 355. The third set 764 to 990. References to the page number in the third set are noted in []. When [] are used it refers to the same document as paginated in the first set.

96. Throughout the course of labor, the fetal heart tracing was reassuring; there was evidence of a steady baseline, good variability and accelerations with intermittent variable decelerations. (Ex. 8 at 200-355; T. 504, 515-516, 1383 and 1393).

97. Patient E spiked a temperature of 101.2 F. (T. 530 and 559).

98. At 8:10 p.m., Respondent noted "Caput is showing. The fetal heart rate tracing was flat with poor beat to beat variability." Such a heart rate is not unusual; as the fetus was hot from being exposed to Patient E's fever, its heart rate increased. When the heart rate is fast, it is very common for there not to be good variability. (Ex. 8 at 22; T. 518).

99. At 8:10 p.m., after noting the fetal heart rate was fast and the tip of the baby's head was showing, Respondent decided to deliver Patient E with the assistance of a vacuum. (T. 518)

100. At 8:55 p.m., Respondent used a vacuum to assist the delivery of the infant. The vacuum was applied at a +3 station. The infant had an Apgar of 5-7-8. (Ex. 8 at 22; T. 401 and 606)

101. When Respondent applied the vacuum, Respondent was reasonably sure of the position of the fetus and confident she was applying it to the vertex, although Respondent was not 100% certain whether it was the lateral, front or rear of the baby's skull. (T. 538-540 and 597-598).

102. The infant was born with metabolic acidosis, severe molding, overlapping skull bones and positive neurological signs. The infant had two seizures, one at 9 hours and a second at 10.5 hours after birth. It also had low hemoglobin and hematocrit, a linear fracture of the parietal bone and a small subarachnoid hemorrhage. (Ex. 8 at 81; T. 404-405, 431-432, 439-440, 601-602 and 605-606).

103. Prior to delivery, the fetus was not in distress. (T. 1384, 1385, 1393, 1401-1403 and 1405).

CONCLUSIONS AS TO PATIENT E

In Allegations E.1(a), (b) and (c), Respondent is charged with (a) failing to recognize the presence of variable and late decelerations in the fetal heart rate monitor tracings throughout labor, (b) not appropriately interpreting the fetal heart rate monitor tracings and/or not recognizing the indications of progressive fetal distress, and (c) failing to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitoring tracings. Throughout labor, the fetal heart rate tracings were reassuring and there was no meaningful evidence of late decelerations. As noted in the conclusions for Patient D, *supra*, The Committee accepts the approach to interpreting fetal heart rate tracings explained by Dr. Manning, an expert witness for Respondent. Fetal heart monitor tracings have to be reviewed in their total context. A particular deceleration in isolation is not meaningful. The whole pattern of the tracing has to be viewed for the presence of a normal baseline, normal long term variability, oscillation in long term variability between periods of increased variability and diminished variability. The Committee finds the fetal heart rate tracings did not indicate the presence of variable or late decelerations, Respondent appropriately interpreted the tracings as reassuring and demonstrated an acceptable level of knowledge of the accurate interpretation of the tracings.

Therefore, Allegations E.1(a), (b) and (c) are not sustained.

In Allegations E.1(d), (e), (f) and (g), Respondent is charged with (d) failing to perform a fetal scalp blood pH test, (e) failing to properly assess the condition of the fetus, (f) not ordering an internal scalp electrode monitor, and (g) failing to act immediately to address signs of fetal distress.

Throughout the course of labor, Respondent regularly and continuously reviewed the tracings of the fetal heart monitor and properly interpreted them as reassuring. At approximately 11:30 a.m., when Respondent observed a "rather flat" rate on the tracing, Respondent used an internal scalp electrode monitor to better discern whether the temporary presence of the flat rate was an indication that the fetus was in distress. Respondent appropriately determined throughout labor that the fetus was not in distress. Since the fetus was not in distress, a fetal scalp blood pH test was not medically indicated. The external fetal heart monitor was transmitting clear tracings and as there is no advantage to an internal monitor, an internal scalp electrode was not indicated. It, however, is noted when Respondent believed an internal scalp electrode monitor was medically warranted to enable her to obtain information as a necessary supplement to the external fetal heart monitor tracings, Respondent appropriately ordered one. Respondent properly assessed the condition of the fetus as one not in distress.

Therefore, Allegations E.1(d), (e), (f) and (g) are not sustained.

In Allegation E.1(h), Respondent is charged with not appreciating and/or demonstrating knowledge of the indications for caesarean delivery. A caesarean section was not indicated for Patient E. Respondent appropriately appreciated that a caesarean was not indicated.

Therefore, Allegation E.1(h) is not sustained.

In Allegation E.1(i), Respondent is charged with inappropriately applying the vacuum to an unknown fetal position. At the time Respondent decided to deliver Patient E with a vacuum assist, Respondent noted the tip of the baby's head was showing. Respondent knew she was applying the

vacuum at +3 station. Respondent was confident she was applying the vacuum to the vertex, although Respondent was not 100% certain of whether it was the lateral, front or rear of the baby's skull. The Committee finds that Respondent appropriately applied the vacuum with adequate knowledge of the baby's position in the canal.

Therefore, Allegation E.1(i) is note sustained.

In Allegation E.1(j), Respondent is charged with failing to maintain a hospital record for Patient E which accurately reflects the condition of the patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery. Respondent and nurses collectively made regular and sufficiently detailed notations of events and findings during the course of labor and delivery. Together with the record of the tracings, the hospital record provides adequate and sufficient detail such that a subsequent physician could understand and reconstruct the treatment Patient E received during the course of labor and delivery.

Therefore, Allegation E.1(j) is not sustained.

VOTE OF THE HEARING COMMITTEE

THE HEARING COMMITTEE VOTES UNANIMOUSLY (3-0) AS FOLLOWS:

FIRST SPECIFICATION:
(Practicing the Profession Negligently on More the One Occasion)

The Hearing Committee hereby determines that the First Specification is not sustained. Although, the Committee finds Respondent failed to meet acceptable standards of medical practice when treating Patient C, (1) in electing to do a transverse incision for a caesarean delivery of Patient

C who is known to have a complete placenta previa, (2) by choosing to leave the operation to locate and repair Patient C's elusive bleeder before hemostasis was accomplished, and (3) by leaving the residents alone in the OR for a period of time without the assistance and/or supervision of an attending physician in the midst of a grave situation of an elusive bleeder, these deviations occurred during the single occasion of delivering Patient C's baby and performing post partum surgery. As the Committee has found no other occasion of negligence, the Committee finds it is not established by a preponderance of the evidence that Respondent practiced medicine negligently on more than one occasion.

NOT SUSTAINED

SECOND SPECIFICATION:

(Practicing the Profession with Incompetence on More than One Occasion)

The Hearing Committee hereby determines that the Second Specification is not sustained. It is not established by a preponderance of the evidence that Respondent practiced medicine incompetently on more than one occasion.

NOT SUSTAINED

THIRD and FOURTH SPECIFICATIONS:

(Practicing the Profession with Gross Negligence)

The Hearing Committee hereby determines that the Third and Fourth Specifications are not sustained as it is not established by a preponderance of the evidence that Respondent practiced medicine with gross negligence in her treatment of either Patient A or Patient B.

NOT SUSTAINED

FIFTH SPECIFICATION:

(Practicing the Profession with Gross Negligence)

The Hearing Committee hereby determines that the Fifth Specification is sustained. Respondent's judgment to elect to do a transverse incision which is contraindicated for Patient C because of the known complete placenta previa and history of prior caesarean section constitutes an egregious deviation from acceptable medical standards. The Committee further finds the Respondent's decision to leave the operating room before completing the surgery to locate and repair an elusive bleeder while Patient C was in a grave condition was conspicuously poor judgment. Respondent had the option to send the chief resident to attend to the new patient who required emergency care. Respondent and the residents had been operating for more than four hours on Patient C. Respondent was the attending physician most familiar with the complications of Patient C's caesarean delivery and the post partum efforts to find and stanch bleeders. The Committee is acutely disturbed at the poor judgment exercised by Respondent who opted to put the interests of the chief resident over the critical needs of Patient C. Moreover, it was egregiously poor judgment in the case of Patient C to leave the operating room without an attending, even for just a few minutes. It is established by a preponderance of the evidence that Respondent practiced medicine with gross negligence in her treatment of Patient C.

SUSTAINED AS TO PARAGRAPHS: C.1(a), (c), (d) and (e).

SIXTH and SEVENTH SPECIFICATIONS:

(Practicing the Profession with Gross Negligence)

The Hearing Committee hereby determines the evidence does not sustain the Sixth and Seventh Specifications.

NOT SUSTAINED.

EIGHTH THROUGH TWELFTH SPECIFICATIONS:

(Practicing the Profession with Gross Incompetence)

The Hearing Committee hereby determines the evidence does not sustain the Eighth through Twelfth Specifications.

NOT SUSTAINED

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATIONS:

(Maintaining Accurate Hospital Records)

The Hearing Committee hereby determines the evidence does not sustain the Thirteenth through Seventeenth Specifications.

NOT SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines the following penalty:

1. Respondent's license is **SUSPENDED FOR A PERIOD OF ONE YEAR AND SAID SUSPENSION IS STAYED** on the following conditions:

    a. Respondent is placed on PROBATION FOR A PERIOD OF ONE YEAR;

    b. Respondent is subject to all standard terms of probation as stated in the Order; and

    c. Respondent shall make available for review by OPMC, and/or in OPMC's discretion, by a physician proposed by Respondent and approved, in writing, by the Director of OPMC, complete copies of any and all medical and office records selected by OPMC of procedures performed during the first six months of the term of probation. Respondent shall fully cooperate in the review process.

ORDER

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

Respondent's license to practice medicine in the State of New York is

1. **SUSPENDED FOR A PERIOD OF ONE YEAR AND SAID SUSPENSION IS STAYED ON THE FOLLOWING CONDITIONS:**

A. **Respondent is placed on PROBATION FOR A PERIOD OF ONE YEAR subject to the following terms;**

(1) Respondent shall make available for review by OPMC, and/or in OPMC's discretion, by a physician proposed by Respondent and approved, in writing, by the Director of OPMC, complete copies of any and all medical and office records selected by OPMC of procedures performed during the first six months of the term of probation. Respondent shall fully cooperate in the review process.

(2) Respondent will conform fully:

(a) to the professional standards of conduct imposed by law and by her profession

(b) with all civil and criminal laws, rules and regulations.

(3) Respondent will notify the OPMC of:

(a) any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within thirty days of each action;

(b) any and all changes in personal and professional addresses and telephone numbers and facility affiliations, within 30 days of such changes. This will include any change in practice location, within or outside of the State of New York. The date of departure from the State of New York and the date of return, if any, must be reported in writing.

Failure to notify the OPMC of any of the above will be considered a violation of probation.

(4) Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

(5) If the Respondent does not practice medicine in the State of New York, the probation period will be tolled and the period will then be extended by the length of the period outside of New York. Any terms of probation which were not fulfilled while Respondent was in New York must be fulfilled upon return to New York State.

(6) A violation of any aspect of the terms of probation shall be considered professional misconduct, pursuant to §230 of the Public Health Law and §6530 of the New York State Education Law.

DATED: New York, New York
February , 1998

CAROLYN C. SNIPE, Chairperson

ROBERT J. O'CONNOR, M.D.
DONNA B. O'HARE, M.D.

APPENDIX A

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

IN THE MATTER

OF

BENTE YAEL HOEGSBERG, M.D.

NOTICE

OF

HEARING

TO: Bente Yael Hoegsberg, M.D.
Centre Road, Box199
Strassburg, New York 12580

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1997) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1997). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on September 3, 1997, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of

"Appendix A"

Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1997) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU

BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1997). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
July 9 ,1997

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to:

Silvia P. Finkelstein, Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER OF BENTE YAEL HOEGSBERG, M.D.	STATEMENT OF CHARGES

BENTE YAEL HOEGSBERG, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 26, 1983, by the issuance of license number NY 15588-1 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about March 15, 1990, Respondent undertook the care and treatment of Patient A, a 36 year old female, weighing 230 pounds. Respondent, a staff attending obstetrician at Jamaica Hospital, ordered that Patient A be admitted for induction of labor. On or about March 16, 1990 at 1:40 a.m., Patient A was 7 centimeters dilated, ~~and~~ membranes were artificially ruptured. After the application of fundal pressure Patient A delivered a stillborn infant at 5:32 a.m. Patient A expired on March 27, 1990. (The Patients are identified in the annexed Appendix).

1. On or about March 16, 1990, on admission to Jamaica Hospital at 1:10 p.m., Patient A was 41 weeks gestation and 2 centimeters dilated. She was observed until 3:30 when induction with pitocin IV was initiated. On March 16, 1990 at 1:40 a.m., Patient A was 7 centimeters dilated and membranes were artificially ruptured

The Patient was fully dilated at 3:20 a.m. when her membranes were ruptured artificially. Mild decelerations with rapid recovery and meconium staining were recorded. Patient A continued to push until 4:50 a.m. when bradycardia was noted. Respondent restarted pitocin in the delivery room. Patient A continued to push and fundal pressure was applied. Following delivery of a stillborn infant at 5:32 a.m. manual removal of the placenta was performed and increased vaginal bleeding was noted. Vaginal bleeding continued. At 7:10 a.m. Patient A had a pulse of 105, no palpable blood pressure, and seizures. A subsequent exploratory laparotomy, 4 hours post delivery, revealed a 15 centimeter laceration of the lower uterine segment. A subtotal hysterectomy, bilateral salpingectomy and oophorectomy were performed. An estimated 10,000 cubit centimeters of blood was found in the pelvic cavity. An autopsy concluded that Patient A's final cause of death was DIC with renal failure, ruptured uterus, prolonged delivery with oxytocin induction and therapeutic complications. Respondent engaged in conduct as follows:

a. Failed to monitor the fetus appropriately;

b. failed to expeditiously deliver Patient A via cesarean section;

c. failed to prepare and/or order that Patient A be prepared for immediate cesarean section;

d. failed to arrange for an operating room to be prepared on an emergent basis for immediate cesarean section;

e. did not call for an anesthesiologist;

f. inappropriately used fundal pressure;

g. failed to monitor the fetus appropriately in the delivery room;

h. did not appropriately act in response to the critical nature of Patient A's condition prior to and subsequent to the stillborn delivery;

i. failed to document post partum uterine exploration;

j. failed to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitor tracings;

k. did not appreciate and/or demonstrate knowledge of the indications for cesarean section;

l. Failed to insure that necessary post partum laboratory tests were done expeditiously;

m. failed to maintain a hospital record for Patient A which accurately reflects the condition of the Patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery;

B. On or about March 18, 1990, Respondent, a staff attending obstetrician, undertook the care and treatment of Patient B, a 20 year old female in active labor admitted to Jamaica Hospital.

1. Respondent performed the delivery utilizing vacuum extraction and Simpson Forceps at 5:10 a.m. Patient B sustained an intentional 4th degree episiotomy. Heavy bleeding continued post-partum and exploration of the uterus and vagina was performed at 3:00 p.m. by another physician. A bleeding left vaginal laceration was revealed necessitating re-opening of the episiotomy and 4th degree repair. Post-partum, Patient B's hematocrit dropped to 5.6/16.7 and she received multiple blood transfusions. Respondent engaged in conduct as follows:

a. failed to expeditiously address Patient B's post-partum hemorrhage;

b. failed to locate and repair the vaginal laceration secondary to the instrumented delivery within a reasonable period of time;

c. failed to appropriately act in response to Patient B's emergent condition post-delivery.

C. On or about June 18, 1992, Respondent, a staff attending obstetrician, undertook the care and treatment of Patient C, a 42 year old female, at 34 weeks gestation with known placenta previa, at St. Luke's/Roosevelt Medical Center.

1. Patient C was admitted at 5:40 p.m. with active vaginal bleeding. Respondent evaluated the Patient and noted that the infant was in a transverse position. A cesarean section was not performed until 7:40 p.m. Respondent did not scrub in but was present in the operating room when a third year resident began the section with a low transverse uterine incision approved by Respondent. The resident had difficulty delivering the infant through this incision and Respondent scrubbed in to extend the incision in the "T" manner, then scrubbed out and left the operating room. Delivery of a live female infant, with an Apgar of 1-6-7 is noted at 8:09 p.m. Respondent did not scrub in again even though the surgery persisted for 4 hours and Patient C had an estimated blood loss of 8,000 cubic centimeters. Another physician, the director of obstetrics, was called in at midnight by the residents to assist in the operating room. A total hysterectomy was performed and surgery was completed on June 19, 1992 at 1:45 a.m. Patient C was taken to intensive care. Respondent engaged in conduct as follows:

a. failed to recognize and adequately manage Patient C's high risk intrapartum course;

b. did not perform an immediate delivery via cesarean section in the presence of active bleeding on admission and known placenta previa;

c. failed to adequately supervise the residents left to perform a complicated and high risk surgical procedure;

d. failed to adequately assist the residents in the surgery of this patient with massive intra-operative hemorrhage;

e. did not appropriately act in response to the complications that arose during the surgery;

f. failed to timely call for a maternal-fetal specialist consultation.

g. failed to maintain a hospital record for Patient C which accurately reflects the condition of the Patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery;

D. On or about October 1, 1993, Respondent, a staff attending obstetrician at St

Luke's/Roosevelt Medical Center, undertook the care and treatment of Patient D, a 28 year old female at 41 weeks gestation.

1. Patient D was admitted at 3:29 a.m. in early active labor. Respondent was notified by nurse midwife at 8:25 a.m. of late decelerations noted in the external fetal heart monitor but did not arrive in the labor room until 9:25 a.m. Infant was delivered at 12:45 p.m. via mid-pelvic vacuum extraction. The infant was in respiratory distress due to meconium aspiration with Apgar scores of 4/6. Infant was intubated and admitted to the neonatal intensive care unit, where cord blood was noted to be acidotic. Skull x-ray and CT scan revealed a small linear skull fracture. Patient D had heavy vaginal bleeding immediately post-partum which continued until 2:30 p.m., at which time a 4th degree rectal tear laceration and a sulcus laceration were recognized and repaired. Patient was discharged on October 7, 1993. Respondent engaged in conduct as follows:

   a. failed to respond within a reasonable period of time after being advised of the presence of fetal distress;

   b. did not properly assess the condition of the fetus;

   c. failed to perform fetal scalp blood pH testing;

   d. failed to order an internal scalp electrode monitor;

e. did not appropriately interpret the fetal heart rate monitor tracings and/or to recognize the indication of progressive fetal hypoxia;

f. failed to recognize the presence of late decelerations with slow return to baseline, an ominous sign of fetal distress;

g. failed to perform an immediate delivery via cesarian section;

h. failed to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitor tracings;

i. failed to appreciate and/or demonstrate knowledge of the indications for cesarian delivery;

j. did not appreciate and/or demonstrate knowledge of the indications for forceps delivery;

k. failed to appropriately perform a forceps delivery

l. inappropriately performed a mid-forceps delivery rather than a low forceps delivery;

m. failed to appropriately assess Patient D immediately

post partum.

n. failed to maintain a hospital record for Patient D which accurately reflects the condition of the Patient, the condition of the fetus, the procedures performed and the timings thereof;

E. On or about January 10, 1995, Respondent, a staff attending obstetrician at Vassar Brothers Hospital, undertook the care and treatment of Patient E, a 34 year old female at full term gestation. Patient E was a private patient of Respondent's group practice.

1. Patient E was admitted at 10:00 a.m. with contractions 5 to 6 minutes apart. She was 2 centimeters dilated, 90 percent effaced, had pregnancy induced hypertension and had been identified as a beta streptococcus carrier. At 1:00 p.m. Respondent noted the fetal monitor strips as "flat". At 8:55 p.m. the infant was delivered by assisted vacuum forceps with an Apgar of 5-7-8. The infant was born with metabolic acidosis, severe molding, overlapping skull bones, and positive neurological signs. The infant had 2 seizures, (at 9 hours and at 10 1/2 hours of age). low hemoglobin and hematocrit, a linear fracture of the parietal bone and a small subarachnoid hemorrhage. The infant was admitted to the neonatal intensive care unit where he was placed on phenobarbital and subsequently discharged to pediatric neurology for follow-up. Respondent engaged in conduct as follows:

a. failed to recognize the presence of variable and late decelerations in the fetal heart rate monitor tracings throughout labor.

b. did not appropriately interpret the fetal heart rate monitor tracings and/or did not recognize the indications of progressive fetal distress;

c. failed to demonstrate an acceptable level of knowledge of the accurate interpretation of fetal heart rate monitoring tracings;

d. failed to perform fetal scalp blood pH testing;

e. failed to properly assess the condition of the fetus;

f. did not order an internal scalp electrode monitor;

g. failed to act immediately to address signs of fetal distress;

h. did not appreciate and/or demonstrate knowledge of the indications for cesarian delivery;

i. inappropriately applied the vacuum to an unknown fetal position;

j. failed to maintain a hospital record for Patient E which accurately reflects the condition of the Patient, the condition of the fetus, the procedures performed and the circumstances surrounding delivery;

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1997) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A.1, A.1.a through A.1.i, A.1.l through A.1.m; B, B.1, B.1.a through B.1.c; C, C.1, C.1.a through C.1.g.; D, D.1., D.1.a through D.1.g , D.1.k through D.1.n; E, E.1, E.1.a through E.1.b, E.1.d through E.1.g, E.1.i and/or E.1.j.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A, A.1, A.1.a through A.1.m; B, B.1, B.1.a through B.1.c; C, C.1, C.1.a through C.1.g.; D, D.1., D.1.a through D.1.n; E, E.1, E.1.a through E.1.j;

THIRD THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1997) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. The facts in paragraphs A, A.1, A.1.a through A.1.i, A.1.l through A.1.m;
4. The facts in paragraphs B, B.1, B.1.a through B.1.c;
5. The facts in paragraphs C, C.1, C.1.a through C.1.g;
6. The facts in paragraphs D, D.1., D.1.a through D.1.g , D.1.k through D.1.n;

7. The facts in paragraphs E, E.1, E.1.a through E.1.b, E.1.d through E.1.g, E.1.i and/or E.1.j.

EIGHTH THROUGH TWELFTH SPECIFICATION
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1997) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

8. The facts in paragraphs A, A.1, A.1.a through A.1.m;
9. The facts in paragraphs B, B.1, B.1.a through B.1.c;
10. The facts in paragraphs C, C.1, C.1.a through C.1.g;
11. The facts in paragraphs D, D.1., D.1.a through D.1.n;
12. The facts in paragraphs E, E.1, E.1.a through E.1.j.

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATION
FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1997) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, as alleged in the facts of:

13. The facts in paragraph A.1.m.

14. The facts in paragraph C.1.g.

15. The facts in paragraph D.1.n.

16. The facts in paragraph E.1.j.

DATED: July 2, 1997
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct