STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

March 27, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Carmen Tarantino, Esq.
Brown & Tarantino, LLP
1500 Rand Building
14 Lafayette Square
Buffalo, New York 14203

Monica J. Applewhite, M.D.
5820 Main Street
Williamsville, New York 14221

RE: In the Matter of Monica J. Applewhite, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-88) 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 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.

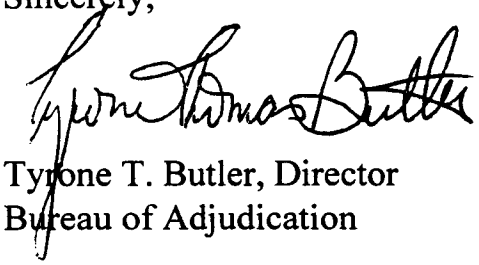
The notice of review served on the Administrative Review Board should be forwarded to:

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:cah
Enclosure

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

COPY

IN THE MATTER

OF

MONICA J. APPLEWHITE, M.D.

DETERMINATION

AND

ORDER

BPMC #02-88

LEMUEL ROGERS, JR., M.D., Chairperson, and **RUFUS NICHOLS, M.D.** and **STEPHEN E. WEAR, PH.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 Section 230(10)(e) of the Public Health Law.

TIMOTHY J. TROST, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	June 27, 2000
Summary Suspension:	June 29, 2000
Pre-Hearing Conference:	August 25, 2000
Place of Hearing:	Airport Radisson Hotel Buffalo, New York

Date of Deliberations: February 14, 2002

Respondent appeared by:

Carmen Tarantino, Esq.
Brown and Tarantino, LLP
1500 Rand Building
14 Lafayette Square
Buffalo, New York 14203

Petitioner appeared by:

Kevin C. Roe, Esq.
NYS Department of Health
Corning Tower Room 2509
Albany, New York 12237

State Witnesses	**Transcript**	**Hearing Dates**	**Index**
Robert Smith, M.D.	pgs. 32-240	9/19/00	Patient A to p. 204 Patient B p. 204-end
Robert Smith, M.D.	245-482	10/2/02	Patient B p. 246-end
Robert Smith, M.D.	487-695	10/3/00	Patient B to p. 667 Patient D p. 668-end
Robert Smith, M.D.	3-164	10/16/00	Patient D to end
Robert Smith, M.D.	4-236	10/17/00	Patient E to p. 103 Patient F p. 104-end
Patient D	1113-1159	11/28/00	
Richard Buckley, M.D.	1164-1190	11/28/00	Witnesses 2,3,4,5,6
Dennis Weppner, M.D.	1191-1200	11/28/00	
Sheri Baczkowski, M.D.	1201-1243	11/28/00	
Amy Lindsley	1244-1296	11/28/00	
Lewis Fein	1322-1356	12/12/00	
Robert Smith, M.D.	1385-1596	12/13/00	Patient G to p. 1479 Patient H to p. 1542 Patient I p. 1543-end
Lewis Fein	1604-1621	1/9/01	

Respondent Witnesses	Transcript	Hearing Dates
James Howard, M.D.	1628-1776	1/9/01
James Howard, M.D.	1787-1895	1/10/01
James Howard, M.D.	1-67	5/4/01
Monica Applewhite, M.D.	5-193	5/25/01
Monica Applewhite, M.D.	5-235	7/11/01
Monica Applewhite, M.D.	5-131	7/12/01
Carmen Tarantino, Esq. (closing argument)		11/9/01

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, fraud, moral unfitness and administrative proceeding.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parenthesis 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. All Hearing Committee findings were unanimous.

1. Monica J. Applewhite, M.D., the Respondent, was licensed to practice medicine in New York State on October 14, 1996, by the issuance of license number 168151 (Not Contested).

PATIENT A

2. Respondent treated Patient A from on or about May 12, 1999, until her death on June 3, 1999, at her office, 5820 Main Street, Williamsville, New York and Millard Filmore Suburban Hospital, 1540 Maple Avenue, Williamsville, New York (Ex. 2A, Ex. 2B).

3. Patient A was a 41 year-old black female with a history of fibroid tumors of the uterus first seen by Respondent on May 12, 1999, with complaints of pelvic pain and dysmenorrhea apparently seeking a second opinion regarding surgical treatment of her fibroid uterus. Respondent recommended exploratory laparotomy and myomectomy, ordered pre-operative radiographic and laboratory testing, and scheduled Patient A for surgery on May 20, 1999. (Ex. 2A, pp. 1-2.)

4. The nurses notes of the May 12, 1999, office visit contain documentation that a PAP test had been performed eight days previously on May 4, 1999, by Dr. Chen, Patient A's previous treating physician. Respondent's records do not contain any documentation of the results of this test, nor that Patient A was aware of the results. The surgery contemplated by Respondent included the inherent risk of an unanticipated abdominal hysterectomy. Prior to the contemplated surgery, Respondent should have confirmed that the previous PAP test was normal by communicating with Dr. Chen or obtaining a copy of the report. Neither

Respondent's office record nor the subsequent hospital record contains documentation that this information was obtained by Respondent prior to surgery. (Ex. 2A, Ex. 2B; T. 38-40.)

5. On May 19, 1999, a pelvic ultrasound performed at Suburban Medical Imaging revealed an enlarged uterus with a complex mass in the adnexa which could not be precisely localized. A transvaginal scan confirmed the presence of an IUD in the endometrial cavity. The radiologist's impression was: "advanced fibroid uterus, with non-visualization of the ovaries, an IUD is in place. There is a large adnexal mass, presumed to be a pedunculated uterine fibroid, although ovarian origin cannot be completely excluded." (Ex. 2A, pp. 8.)

6. Pre-operative laboratory studies were performed at Millard Filmore Suburban Hospital on May 19, 1999. White blood count was 17.4 (H), red blood count was 3.74 (L), hematocrit was 35.6 (L), MCH was 32.5 (H), platelet count was 601 (H), neutrophil was 14.5 (H), and albumin was 3.2 (L). (Ex. 2B, pp. 120-121.)

7. On May 19, 1999, a pre-operative history and physical examination was performed at the Millard Filmore Suburban Hospital by Deborah Fresch, FNP-C. Examination of the abdomen was reported as "rounded, positive bowel sounds, soft with diffuse tenderness, unable to fully assess due to guarding." Genital, rectal, and pelvic examinations were deferred to Respondent. Respondent noted that the abdomen was "very tender and erythemetous, irregular, palpated to ziphoid? Very tender on pelvic exam." (Ex. 2B, pp. 65-66.)

8. In an operative report dated May 28, 1999, Respondent documented that within the past two weeks, Patient A complained of "much more abdominal pain" and had a low-grade temperature. (Ex. 2B, pp. 159.)

9. By on or about May 20, 1999, laboratory studies showed a high white blood count with a shift to the left indicative of infection. The abdomen was very tender and erythematous. Pelvic exam was documented as "very tender." The patient was complaining of "much more" abdominal pain and had a low-grade fever. Given the information available, Respondent should have removed the IUD, cultured the cervix for possible infection and initiated IV antibiotic therapy while awaiting results of the culture. (T. 44-47.)

10. On May 20, 1999, surgery was canceled ostensibly because additional radiographic studies (IV pyelogram and barium enema) were not performed. Surgery was rescheduled for May 28, 1999. (Ex. 2B, Ex. 2C.)

11. On May 27, 1999, Respondent was contacted by the anesthesiologist at Millard Filmore Suburban Hospital, Dr. Zafar, regarding the elevated white blood count on May 19, 1999. Respondent ordered repeat laboratory studies. (Ex. 2C, pp. 151, 68.)

12. Patient A was admitted to Millard Filmore Suburban Hospital on May 28, 1999, for the proposed surgery. Repeat laboratory studies showed an elevated white blood count of 19.1. Pre-operative temperature was documented as 100.9. (Ex. 2C, pp. 108, 154.)

13. At surgery, upon opening the abdomen, Respondent found a large abscess. This finding was not anticipated. A stat surgical consult was called and approximately 600 cc of pus was drained from the abscess. The surgeon on duty was Richard Buckley, Jr., M.D. When Dr. Buckley arrived, the abdomen was re-prepped and the incision was extended above the umbilicus to the xiphoid. Examination of the abscess cavity revealed that it started above the fascia and that an aspect of it was below the rectus abdominis fascia. Dr. Buckley examined the contents of the pelvis to determine whether the source of the infection could be located and treated surgically if necessary. There was no evidence of any perforation of the large or small bowels. The abdomen was copiously irrigated. At this point, Dr. Buckley advised Respondent that he and his assistant would close the abdomen. Respondent indicated that she wished to proceed with the planned elective surgery. Dr. Buckley advised Respondent that because the surgical field was contaminated by infection, he thought it best to close the abdomen at that time and return at a later date. Respondent again indicated her intention to proceed with elective surgery. Dr. Buckley reiterated his recommendation to close the abdomen and defer elective surgery to a later date. Respondent excused Dr. Buckley from the operating room. (Ex. 2B, pp. 159-161; T. 1170-1171.)

14. After Dr. Buckley and his assistant left the operating room, Respondent proceeded with elective surgery performing tubal ligation, multiple myomectomies, and surgical removal of an IUD from the endometrial cavity. Continuation of surgery through a contaminated surgical field increased the risk and created a likelihood of spreading infection. Continuation of elective surgery on Patient A was contraindicated and contrary to accepted standards of medical care. (Ex. 2B, pp. 159-160; T. 58-59.)

15. Post-operatively, Patient A's white blood cell count remained elevated and platelet count remained elevated at 732,000 on May 29 and 871,000 on May 30 despite draining of the abscess and adequate IV antibiotic therapy. An internal medicine and/or hematology consult should have been obtained to evaluate and/or treat the abnormal laboratory values. (Ex. 2B, pp. 108; T. 66-67.)

16. Late on the evening of May 31, 1999 (post-operative day three), Patient A became slightly hypoxic, short of breath, and was noticed to have a rapid pulse. The next day her condition worsened appreciably. She required intubation, suffered two episodes of cardiopulmonary arrest, and was comatose until her death on June 3, 1999. An autopsy performed June 5, 1999, determined the cause of death to be sepsis. (Ex. 2B, pp. 78-95, Ex. 2C.)

CONCLUSIONS

Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

- Respondent failed to confirm that a previous Pap smear was normal.

- Respondent failed to order and/or obtain a cervical culture for gonorrhea and chlamydia testing.

- Respondent failed to order and/or administer adequate pre-operative antibiotic therapy.

- Respondent performed elective surgery through an infected surgical field.

- Respondent failed to order and/or obtain internal medicine and/or hematology consultations in a timely manner.

- Respondent failed to review May 19, 1999 laboratory reports in a timely manner.

PATIENT B

17. Respondent treated Patient B from on or about June 19, 1998, until her death on February 5, 1999, at her office and Millard Filmore Suburban Hospital (Ex. 3A, Ex. 3C, Ex. 3D.)

18. Patient B was first seen at Respondent's office on June 19, 1998 for possibly pregnancy. HCG quantitative testing confirmed pregnancy and Patient B returned on July 17, 1998. At the July 17 office visit Patient B gave a history that a PPD test for exposure to Tuberculosis was positive at 3 cm. And that the "doctor at the TB lab said he didn't see any infection." Tuberculosis is a dangerous infection that can worsen during pregnancy, when the immune system is diminished. A report of a recent positive test for tuberculosis is significant and should be followed-up by obtaining the records and/or consulting with the physician at the TB clinic. Respondent's records after July 17, 1998 contain no documentation that such effort was undertaken. (Ex. 3A, pp. 6; T. 206-208.)

19. By mid-1998, it was standard of care to screen all pregnant women for HIV regardless of risk factors. Respondent did not offer HIV screening to Patient B, nor did she offer and/or obtain such testing. (Ex. 3A; T. 209-210, 348-349, 534-538, 589-591.)

20. Diabetes mellitus is the most common medical complication of pregnancy. Approximately 2-3 percent of pregnancies are affected by diabetes; 90 percent of these cases represent gestational diabetes mellitus (GDM). Maternal hyperglycemia leads fetal to hyperglycemia and fetal hyperinsulinemia, a combination which may case fetal macrosomyia and fetal death

as well as delayed pulmonary maturation. Therefore, diabetic women should attempt to achieve and maintain euglycemia throughout pregnancy. Screening for GDM is performed with a 50-g oral glucose load followed by a glucose determination one hour later (one hour glucose challenge test). It is standard of care to screen all patients for GDM between 24 and 28 weeks of pregnancy and earlier if the patient has risk factors such as previous history of GDM. If screening in early pregnancy yields a normal result, subsequent testing should be performed at 24-28 weeks. Patients whose plasma glucose levels equal or exceed 140 mg/dl should be evaluated with a diagnostic three-hour glucose tolerance test (GTT). (Ex. 18; T. 210-213.)

21. During this pregnancy, Patient B was a 37 year-old, black female, gravida 6, para 5, AB 1 with a history of gestational diabetes during her last three pregnancies and a family history of diabetes. She was obese. Based on her age, weight, and history, Patient B was at very high risk for development of GDM. (Ex. 3A; T. 210-213.)

22. Laboratory studies performed on June 26, 1998 showed a random serum glucose level of 137. This value was abnormally high and warranted immediate further evaluation with a fasting blood sugar test or one-hour glucose challenge test. No further tests were ordered by Respondent until July 17, 1998. (Ex. 3A, pp. 36; T. 214-216.)

23. A one hour glucose challenge test (the appropriate screening test for GDM), was ordered on July 17, 1998 and performed on July 27, 1998, revealed an abnormally high serum glucose level of 153. This result warranted immediate diagnostic testing for GDM with a 100 gm

glucose tolerance test. Respondent did not order any further testing until August 26, 1998. (Ex. 3A, pp. 31; T. 216-217.)

24. On August 26, 1998, a second one hour glucose challenge test was ordered and performed resulting in an abnormally high serum glucose level of 184. A 100 gm glucose tolerance test was scheduled and performed on September 3, 1998. It showed abnormally high two-hour and three-hour serum glucose levels. Respondent referred Patient B to R&B Medical Group (Dr. Hall) for further evaluation and consultation. (Ex. 3A, pp. 32-33; T. 217-219.)

25. Patient B was seen by Dr. Hall September 14, 1998. After evaluation, Dr. Hall educated Patient B regarding GDM, diet, and use of a glucometer. Dr. Hall recommended a 2200 calorie American Diabetes Association diet, use of a glucometer, and maintenance of fasting glucose at 100 or less and 2 hour postprandial levels of 120 or less. (Ex. 3A, pp. 11-12.)

26. A glucometer is a blood glucose monitoring system used by a patient at regular intervals during the day in conjunction with a diary. Patient B obtained an Accu-Check glucometer on September 30, 1998, and regularly used this device from October 3, 1998 to December 20, 1998. (Ex. 3K; stipulation at T. 11/9/01, pp. 14-15.)

27. After the glucose tolerance test performed by Dr. Hall on September 14, 1998, and prior to admission to the hospital on January 5, 1999, Respondent neither performed nor ordered serum glucose levels to monitor and evaluate GDM. Although Patient B was using a glucometer and keeping a diary, Respondent did not evaluate this information. In fact,

Respondent's record falsely reports that Patient B never obtained a glucometer. (Ex. 3A, pp. 4-8; T. 220-222.)

28. Patient B was seen at Respondent's office for a prenatal visit on October 9, 1998, at 26 weeks of pregnancy by date and ultrasound. She had lost 8 1/4 pounds in the last month since her previous office visit. Fundal height was documented at 32 cm. The discrepancy between fundal height and gestational age, together with the patient's known gestational diabetes mellitus, warranted evaluation of the pregnancy by ultrasound to assess the risk of macrosomia, fetal hydrops, and/or fibroids. An ultrasound was not ordered or performed. (Ex. 3A, pp. 7; T. 223-224.)

29. Hypertensive disease complicates roughly 6-8% of pregnancies in the United States and ranks second only to embolism as a cause of maternal mortality; it is directly responsible for 15% of maternal deaths in the United States. Maternal hypertension is also an important cause of perinatal morbidity and mortality, secondary to both direct fetal effects and iatrogenic preterm delivery performed for maternal indications. Despite the importance of this condition, its origin remains obscure, and the disease process is ultimately reversed only by delivery. Pregnancy induced hypertension (PIH) is a multiorgan disease process that may involve much more than elevated blood pressure. Several clinical subsets are recognized, depending on end organ effects. Some such subsets have traditionally been given distinct labels, for example preeclampsia when renal involvement leads to proteinuria, eclampsia when central nervous system involvement leads to seizure, and HELLP syndrome when the clinical picture is dominated by hematologic and hepatic manifestations. Although PIH may represent a final

common pathway for a number of pathologic processes, given the limitations of current understanding, the terminology should not be taken to connote intrinsically different disease entities. Pregnancy induced hypertension is diagnosed when blood pressure rises to 140/90 or greater after 20 weeks of pregnancy. Preeclampsia is traditionally diagnosed by the identification of pregnancy-induced hypertension plus protenuria or generalized edema. Recently, edema has been discounted as an indicator of preeclampsia. Clinical manifestations of severe PIH include systolic blood pressure greater than 160 mm Hg or diastolic blood pressure greater than 110 mm Hg; protenuria 2+ or more; symptoms suggesting significant end organ involvement such as headache, visual disturbances, hypereflexia, epigastric or right upper quadrant pain; elevated serum creatinin; seizures; pulmonary edema; oliguria; microangiopathic hemolysis; thrombocytophenia; hepatocellular dysfunction; and intrauterine growth retardation or oligohydramnios. The differentiation between mild and severe PIH cannot be rigidly pursued because mild disease may progress rapidly to severe disease. Delivery remains the only definitive treatment for PIH. For this reason, delivery is generally indicated in women at term with PIH of any severity and in preterm women with severe disease. For preterm patients with mild PIH, conservative management is generally indicated. For any patient with PIH not undergoing delivery, it is essential to closely monitor blood pressure and protenuria; and to evaluate renal and hepatic function and platelet count. Serial sonography for fetal growth and antipartum assessment of fetal well-being is also important. (Ex. 17; T. 225-312, 527-630.)

30. Patient B was seen for an office visit at Respondent's office on December 18, 1998, at 37 weeks of pregnancy by dates and ultrasound. Fundal height was recorded at 43 cm. She had

gained 5 ½ pounds during the previous week. Blood pressure was 120/90. Blood pressures had previously ranged from 110-130/70-80. The elevated blood pressure, continued discrepancy between gestational age and fundal height, and the patient's known GDM, warranted immediate further evaluation of the pregnancy with a biophysical profile. A biophysical profile was ordered but was not performed until December 22, 1998. (Ex. 3A, pp. 7; T. 225-227.)

31. Patient B was seen at Respondent's office for a prenatal visit on December 23, 1998, at 38 weeks of pregnancy. Blood pressure was 154/90. 2+ protenuria was noted. Fundal height was measured at 45 cm. Deep tendon reflexes were not tested. Presence or absence of headache, visual disturbances, and/or epigastric pain was not obtained. Patient counseling regarding bed rest and low salt diet was not performed. The patient's condition warranted admission to the hospital for evaluation of pregnancy induced hypertension and possible delivery, fetal non-stress tests and/or biophysical profile to evaluate fetal status; and laboratory studies to include CBC with platelet count, uric acid, liver function tests, and clotting studies. Respondent did not recognize the patient's worsening pregnancy induced hypertension and did not order and/or obtain appropriate evaluation. (Ex. 3A, pp. 7; T. 246-248.)

32. Patient B returned to Respondent's office for a prenatal visit on December 30, 1998, at 39 weeks gestation. Blood pressure was 160/90. 3+ protenuria was noted. Fundal height was measured at 45 cm. Deep tendon reflexes were not checked and information regarding headache, visual disturbances, and/or epigastric pain was not obtained. Patient counseling

regarding bed rest and low salt diet was not undertaken. Patient B's condition warranted immediate admission to the hospital for evaluation of persistent and worsening pregnancy induced hypertension and possible delivery. Evaluation should have included fetal non-stress test and/or biophysical profile to assess fetal well being and appropriate laboratory studies to assess PIH. Respondent planned to admit Patient B to the hospital for induction of labor on January 4, 1999. No evaluation or monitoring was planned, ordered, or performed during the interim. (Ex. 3A, pp. 7; T. 249-254.)

33. Patient B was admitted to Millard Filmore Hospital on January 5, 1999. Weather conditions apparently delayed the admission planned on January 4, 1999. Respondent's admission diagnosis was stable intrauterine pregnancy, fetal macrosomia. (Ex. 3D, pp. 42.) Admission orders for oxytocin induction of labor were received by telephone from Respondent on January 4, 1999 at 7:30 a.m. No laboratory studies were ordered. Admission orders for oxytocin induction of labor were received verbally from Respondent on January 5, 1999 at 4 p.m. Routine labor and delivery orders, including laboratory testing with CBC with differential and type and screen, were received at 5:45 p.m. Respondent's admission orders should have included serum glucose determinations to evaluate status of GDM and a full toxemia panel to evaluate status of PIH. (Ex. 3D, pp. 14-16, 40-42; T. 254-256.)

34. After admission at 5 p.m., Pitocin was administered resulting in delivery of a 9 pound 14 ounce female with apgar scores of 4/9 at 9:29 p.m. Blood pressure during labor averaged 150/70-80. (Ex. 3D, pp. 115-120.)

35. At 8 a.m. on January 6, 1999, blood pressure was 160/100 and the patient was instructed to lay on her left side for 15 minutes. At 8:15 a.m. blood pressure was 170/100. Amy Lindsley, Certified Nurse Midwife was called to evaluate the patient. At 8:20 a.m., Ms. Lindsley noted that Patient B was complaining of a headache but denied visual disturbances, dizziness or epigastric pain. Blood pressure was 160/100. Blood pressure in the left lateral position was 170/100. 2+ pitting protibial, pedal edema was noted bilaterally. Deep tendon reflexes were noted as 1+. The patient's condition was discussed with Respondent, Tylenol was ordered for headache and urinalysis was ordered to check for protein. (Ex. 3D, pp. 42, 144.)

36. At 10:15 a.m. on January 6, 1999, Respondent evaluated Patient B. Blood pressure was 160/96. Urinalysis obtained at 8:30 a.m. revealed 3+ protein in the urine and a large amount of blood in the urine. Deep tendon reflexes were not tested. Appropriate laboratory studies (toxemia panel) were not ordered. Magnesium sulfate, to prevent seizures was not ordered. IV apresoline, or other medications to lower blood pressure was not ordered. Respondent's assessment was; stable except for elevated blood pressure. She planned to continue to monitor Patient B. (Ex. 3D, pp. 43, 91, 144.)

37. At 12:15 p.m. on January 6, 1999, blood pressure was 160/100 and the patient was medicated with Percocet for headache. At 2 p.m. blood pressure was 160/90. At 3 p.m. blood pressure was 140/90 and the patient remained resting on her left side. At 5:00 p.m. blood pressure was 170/116 and the patient complained of headache, visual disturbances and nausea. After laying on her left side for 20 minutes recheck blood pressure was 160/112. Nurse Midwife Lindsley was called. (Ex. 3D, pp. 144.)

38. At 5:20 p.m. on January 6, 1999, Amy Lindsley, CNM, evaluated Patient B. Elevated blood pressure, complaints of headache, blurry vision and nausea as set forth above were noted. 2+ pitting pretibial pedal edema bilaterally and 3+ protenuria were noted. Ms. Lindsley's assessment was: increased blood pressure rule out toxemia. Ms. Lindsley called Respondent who ordered transfer to labor wing, Apresoline 5 mg IM, 6 gm loading dose of magnesium sulfate, toxemia panel, check magnesium level, and aldomet IV "per M.D." Ms. Lindsley was uncomfortable with Respondent's orders and plan. At 5:48 p.m. Ms. Lindsley called Respondent and asked her to come into the hospital to see the patient. Ms. Lindsley called Sheri Baczkowski, M.D., the in-house attending physician, and asked her to evaluate Patient B. (Ex. 3D, pp. 43; T. 96-102, 143-153.)

39. At 5:55 p.m., Dr. Baczkowski evaluated Patient B at the request of Ms. Lindsley. Dr. Baczkowski reviewed the hospital chart including prenatal records. She noted:

> Patient complained of worsening headache throughout the day with scotomata and without right upper quadrant pain. Leg edema has progressed throughout the day as per the Certified Nurse Midwife who evaluated patient throughout the shift. Prenatal records reveal that the patient most likely started developing toxemia at 38 weeks 12/23/98. Baseline blood pressure was 110/70. Blood pressure on 12/23/98 was 154/90 on 12/30/90 was 160/90 with 2+ and 3+ protenuria. (Emphasis added)

After physical examination, including deep tendon reflexes, and review of laboratory studies, Dr. Baczkowski diagnosed severe HELLP, severe toxemia, and disseminated intra vascular coagulation (DIC). She ordered strict input/output; place Foley catheter; and restrict oral and intravenous intake to 125 cc's per hour; 6 gm IV loading dose of magnesium sulfate with continuous IV drip at 3 gm per hour for 24 hours; check magnesium sulfate level 1 hour after loading dose completed; toxemia protocol; bed rest; Labetolal drip if blood pressure increases above 170/105; recheck toxemia and hepatic laboratory studies every 6 hours, if DIC worsens (i.e. platelet count falls below 20,000) consider platelet transfusion. (Ex. 3D, pp. 44-45.)

40. At 8 p.m. on January 6, 1999, two and a half hours after first called by Ms. Lindsley, Respondent evaluated Patient B. Platelet count was low at 53,000. Respondent's assessment was: stable; severe toxemia. Her plan was to continue monitoring, watch platelet count and monitor blood pressure. At 8:15 p.m., she instructed nursing staff "please call me at home if any problems" and left the hospital. (Ex. 3D, pp. 19, 46.)

41. In the physician's progress note written by Dr. Baczkowski on January 6, 1999 at 5:55 p.m., Respondent circled the notation "2+ & 3+ protenuria" and wrote the words "Acetone not protenuria" in the adjacent left-hand margin. Respondent knew this information to be false. This was an attempt to deceive subsequent reviewers of the record regarding the status of the pregnancy at 38-39 weeks gestation. In the copy of the prenatal record contained in the hospital chart, Respondent knowingly and falsely added the letters "cetone" to the column heading "A", making it appear that the 2+ and 3+ protenuria on December 23 and December 30, 1998 was acetone. On the original prenatal record contained in her office chart,

Respondent knowingly and falsely added the letters "cetone" to the column heading "A", making it appear that the 2+ and 3+ protenuria on December 23 and December 30, 1998 was acetone. (Ex. 3A, pp. 7, Ex. 3D, pp. 27, 44.) When interviewed by Department of Health employees on April 27, May 11, and June 8, 2000, Respondent continued to claim that Patient B had 2+ and 3+ acetonuria and not 2+ and 3+ proteinuria on December 23 and December 30, 1999. During her testimony at this hearing, Respondent acknowledged that Patient B had 2+ and 3+ proteinuria on December 23 and December 30, respectively. (Ex. 3A, Ex. 3B, Ex. 3D, Ex. 14, Ex. 15, Ex. 16.)

42. Starting at 8:30 p.m. on January 6, 1999, vital signs were documented every half hour until 3 a.m. on January 7, 1999, then hourly until 6 a.m., then every 15 minutes thereafter. Blood pressure averaged 170/90 with pulse rate of 95 until 1 a.m. Thereafter the pulse rate rose to 110/120 for the next few hours. Urine output was very high during this time. From 8:30 p.m. on January 6 until 6 a.m. on January 7, 1999, 3800 cc's of output was recorded. At 10 p.m. on January 6, 1999, Respondent was informed of the patient's status and made aware of the urine output. IV fluid replacement was not ordered. After 3 a.m., the patient's pulse rose to the 120's and 130's. Her blood pressure was down as low as 124/68. At 4 a.m. urine continued to drain and was slightly bloody. At 6 a.m. Patient B was difficult to arouse. Urine was more bloody. Respondent was notified and ordered a serum magnesium level and decreased magnesium sulfate to 1 gm per hour. She did not respond to the hospital nor request evaluation by another physician. At 7:30 a.m. on January 7, 1999, Patient B was unresponsive to verbal stimuli. Respondent was called and notified of the patient's unresponsive level of consciousness and recent lab work. She stated that she would be in

soon to evaluate the patient. Nursing staff called Dennis Weppner, M.D., Chief of Obstetrics and Gynecology. Dr. Weppner evaluated the patient at 7:45 a.m. and assumed her care. Respondent arrived at the hospital between 8:30 and 9 a.m., approximately three hours after being notified that Patient B was obtunded. (Ex. 3D, pp. 19-20, 46-47, 144-156; T. 268-299.)

43. Despite appropriate efforts by Dr. Weppner and consulting physicians called by him, Patient B coded at 12:30 p.m. on January 7, 1999, was resuscitated with electric shock and intubated. She had a long downhill course thereafter. The physicians treating Patient B believed she sustained renal cortical necrosis from either shock or the DIC associated with HELLP syndrome, or hemolytic uremia syndrome or thromobcytopenic purpurea. Patient B developed pneumonia and stayed on a respirator. She had subarachnoid and intra ventricular hemorrhages. She was on dialysis for renal failure. Patient B coded on February 4, 1999, and again on February 5, 1999, when she died. An autopsy performed February 6, 1999, determined cause of death to be disseminated intravascular coagulation due to HELLP syndrome. (Ex. 3C, Ex. 3D, Ex. 3H.)

44. During the course of the OPMC investigation regarding Respondent's care and treatment of Patient B, a copy of Respondent's office record was requested on June 1, 1999. Respondent provided Exhibit 3A on June 12, 1999. On June 16, 1999, OPMC returned the copy of the records to Respondent and requested that she complete and sign a certification form and return it with a copy of her records. On June 18, 1999, Respondent provided Exhibit 3B to OPMC with a certification form signed that day. The physician progress notes contained in Exhibit 3A are different from the physician progress notes contained in Exhibit 3B. Neither

version of Respondent's physician progress notes for this patient were made contemporaneous to the events reflected therein. A comparison of these differences is contained in Exhibit 3F. When the existence of two separate and different sets of progress notes was pointed out to Respondent during interview with OPMC on May 11, 2000, Respondent terminated the interview and failed to offer any explanation at that time. On June 8, 2000, during a third interview of Respondent with OPMC, Respondent claimed that the progress notes in Exhibit 3B were re-written after Exhibit 3A was returned to her when she noticed that the physician progress notes in Exhibit 3A were in "incomplete." Exhibit 3B contains no notation that the physician progress notes were created a year and a half after the events reflected therein. At hearing, under oath, Respondent offered a different explanation for the existence of two different sets of physician progress notes. (Ex. 3A, Ex. 3B, Ex. 14, Ex. 15, Ex. 16, Ex. 3F; T. 1322-1356, 7/11/01 144-150.)

CONCLUSIONS

Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

- Respondent failed to follow-up on a historical report of possible tuberculosis.

- Respondent failed to order and/or obtain HIV tests.

- Respondent failed to order and/or obtain fasting blood sugar testing on or about June 26, 1998.

- Respondent failed to obtain a glucose tolerance test in a timely manner prior to September 3, 1998.

- Respondent failed to adequately monitor blood sugar levels from October 6, 1998 to admission.

- Respondent failed to order and/or obtain an ultrasound on or about October 9, 1998, or in a timely manner thereafter.

- Respondent failed to obtain a biophysical profile on December 18, 1998, or in a timely manner prior to December 22, 1998.

- Respondent failed to hospitalize Patient B for evaluation of pregnancy-induced hypertension and possible delivery on or about December 23, 1998.

- Respondent failed to order and/or obtain fetal non-stress tests and/or biophysical profiles on or about December 23, 1998.

- Respondent failed to obtain appropriate laboratory studies to evaluate the patient's worsening PIH on or about December 23, 1998.

- Respondent failed to order and/or obtain non-stress tests and/or a biophysical profiles on or about December 30, 1998.

- Respondent failed to obtain appropriate laboratory studies to evaluate the patient's worsening PIH on or about December 30, 1998.

- Respondent failed to admit Patient B to the hospital in a timely manner on or after December 30, 1998.

- Respondent failed to order appropriate laboratory studies at admission.

- Respondent failed to adequately attend Patient B postpartum.

- Respondent failed to adequately evaluate, diagnose and/or treat postpartum PIH.

- Respondent failed to adequately evaluate, diagnose and treat HELLP syndrome.

- Respondent falsely altered her office medical record by creating a second set of progress notes and by falsely altering other entries.

PATIENT D

45. Respondent treated Patient D from on or about April 14, 1995, to on or about November 14, 1995, at her office and Millard Filmore Suburban Hospital. During the pregnancy in question, Patient D was a 30 year-old black physician with a history of hypertension. This was her first pregnancy. (Ex. 5A, Ex. 5B, Ex. 5C, Ex. 5D.)

46. Shortly before October 1, 1998, the Department of Health requested copies of Respondent's office record for Patient D. By letter dated October 1, 1998, Respondent forwarded Exhibit 5A to the Department of Health with the explanation that most of the original records had been given to the patient. Patient D did not receive the originals or copies of her records from Respondent's office. Exhibit 5A contains only the front page of the prenatal record. Neither the prenatal chart, physician's progress notes nor nursing notes are contained therein. The Millard Filmore Suburban Hospital record for Patient D includes copies of the front page and prenatal chart up to the office visit of October 3, 1995. The hospital record does not contain either physician progress notes, nurses notes, or complete prenatal laboratory studies. In December of 1997 and January of 1998, Patient D requested that Respondent forward a copy of her records to Angel Kerney, M.D., a subsequent treating physician. Sometime thereafter, Respondent sent a copy of the records to Dr. Kerney. Exhibit 5B is the original copies provided by Respondent to Dr. Kerney. It contains the front page and complete prenatal chart with the last entry of November 8, 1995. It does not contain physician progress notes, nurses notes or prenatal laboratory studies. Respondent's prenatal records for Patient D were either lost, misplaced, or destroyed. (Ex. 5A, Ex. 5B, Ex. 5C, Ex. 5D; T. 1116-1117.)

47. Genetic screening with an alpha fetoprotein testing is standard of care for all pregnancies. pregnancy women should be counseled regarding this test, the test recommended and obtai if the patient so desires. The results of an alpha fetoprotein test may suggest neural tube defect, anencephaly, gastroschisis, or Downe's Syndrome. Based on the results, further testing and/or decision making may be necessary. Respondent did not counsel, recommend obtain, or perform genetic screening for Patient D. (Ex. 5A, Ex. 5B, Ex. 5C, Ex. 5D; See 1118.)

48. Patient D was seen at Respondent's office for a prenatal visit on November 8, 1995, at 40 weeks gestation. From historical information provided by Patient D at admission to the hospital on November 9, her blood pressure during this office visit was 175/97 with numbn of her right forearm and fingers. No blood pressure was documented by Respondent for thi office visit. Urine was not obtained or tested for the presence of protein. Deep tendon reflexes were not tested. Information regarding the presence or absence of headache, visua disturbance and/or epigastric pain was not obtained from the patient. Urine should have be obtained and tested for the presence of protein, blood pressure should have been recorded, a further historical information obtained to properly evaluate PIH. Patient D was sent to Children's Hospital of Buffalo for an outpatient non-stress test and biophysical profile. Patient D was at term. Her blood pressure of 175/97 warranted admission to the hospital fo evaluation and ultimate delivery. (Ex. 5B; T. 686-689.)

49. At or about 2:15 p.m. on November 8, 1995, Patient D was evaluated by nursing personnel Children's Hospital of Buffalo. Blood pressure was 175/95 and 124/62. Urine was negativ

for protein, leukocytes, ketones, glucose and blood. Patient D denied headache, blurry vision, scotomata and epigastric/right upper quadrant pain. Slight edema of the hands and face were noted. Deep tendon reflexes were 2+ and brisk. Biophysical profile revealed a low amniotic fluid index of 6 cms. While amniotic fluid is a late finding of placental insufficiency, it has potentially grave prognostic significance and calls for delivery. Children's Hospital of Buffalo personnel recommended admission to that facility, but Patient D preferred to deliver at Millard Filmore Suburban Hospital where she worked. Patient D was instructed to go straight to Respondent's office and then to Millard Filmore Suburban Hospital for delivery. These findings, instructions, and recommendations were discussed with Respondent. (Ex. 5C; T. 1121-1122.)

50. Patient D returned to Respondent's office on November 8, 1995. Based on the patient's condition immediate admission to Millard Filmore Suburban Hospital was warranted. Respondent instructed Patient D to go home and made arrangements for admission the following day. (Ex. 5D; T. 1122-1123.)

51. Patient D was admitted to Millard Filmore Suburban Hospital on November 9, 1995, at 7:05 a.m. for induction of labor and delivery. Prostaglandin gel was placed at 9:23 a.m. Blood pressures were documented at follows: 7:20 a.m. 148/86, 9:20 a.m. 148/81, 9:45 a.m. 146/88, 10 a.m. 146/88, 10:15 a.m. 134/90, 10:30 a.m. 138/92, 11 a.m. 145/100, 11:30 a.m. 138/88, 12:15 p.m. 136/86, 1 p.m. 140/90, 2 p.m. 130/86, 3:30 p.m. 148/104, 3:45 p.m. 150/92, 5:30 p.m. 150/88, 7:30 p.m. 130/92, 9:45 p.m. 156/102, 10:15 p.m. 154/94, 10:30 p.m. 157/86, 11 p.m. 150/80. (Ex. 5D, pp. 33-37.)

52. Respondent evaluated Patient D at 11:45 a.m. on November 9, 1995. Blood pressure had reached 154/100 at 11 a.m. Respondent ordered monitoring of blood pressure, intermittent external fetal monitoring, and laboratory studies including clotting times, some liver enzymes, and uric acid determination. She planned to observe the patient and consider use of magnesium sulfate. Repeat urinalysis at 4 to 6 hour intervals should have been ordered to evaluate for proteinuria. Magnesium sulfate should have been ordered to prevent seizures. (Ex. 5D, pp. 15-16, 36, 111; T. 10/16/00 pp. 8-9.)

53. Respondent saw Patient D at 2:00 p.m. on November 9, 1995. According to the nursing notes, no progress note was written and no orders were given. (Ex. 5D, pp. 36.)

54. Respondent next attended Patient D at 3:10 p.m. on November 10, 1995. During the twenty-five hours between visits by Respondent, blood pressure was occasionally elevated. Urinalysis was not obtained. Deep tendon reflexes were not tested. Laboratory studies to evaluate PIH were not obtained. At 8:10 a.m. on November 10, 1995, Pitocin was initiated without evaluation by Respondent. (Ex. 5D, pp. 40-44; T. 10/16/00 pp. 10-14.)

55. At 1:30 p.m. on November 10, 1995, a pelvic examination was performed by a nurse. The cervix was 2 cm dilated, 70 percent effaced and station was -2/-3. At 3:10 p.m., a pelvic examination was performed by Respondent. The cervix was 4 cm dilated, 90 percent effaced, and station was -1. An amniotomy was performed. At 3:30 p.m., a pelvic examination was performed by Respondent. The cervix was 7 cm dilated, effacement was not documented, and station was -1. At 4:20 p.m., a pelvic examination was performed by Respondent. The cervix

was 7 cm dilated, effacement was not documented, and station was -1. Respondent left the hospital. At 5:30 p.m., a pelvic examination was performed by a nurse. The cervix was 7cm dilated, 100 percent effaced and station was -1. At 6:30 p.m., a pelvic examination was performed by a nurse. The cervix was 7+ cm dilated, 100 percent effaced, and station was -1. At 8 p.m., a pelvic examination was performed by Dr. Kim, a resident. The cervix was 7 cm dilated and station was -1. At 8:30 p.m., a pelvic examination was performed by Respondent. The cervix was 7 cm dilated. Neither station nor effacement were documented. At 8:50 p.m., Respondent documented the condition of the cervix to be anterior lip (almost fully dilated). At 9 p.m., Respondent noted that the patient was fully dilated. At 10:30 p.m., a pelvic examination was performed by a nurse. The cervix was 7.5 cm dilated, and station was -1. The cervix was noted to be edematous. At 10:35 p.m., Respondent called for a caesarean section. At 11:20 p.m., Patient D delivered a 6 pound, 15 ounce male infant with Apgar scores of 9/9. (Ex. 5D, pp. 41-48, 57-58.)

56. At 3:10 p.m. on November 10, 1995, examination by Respondent showed 7 cm dilated. Respondent instructed the patient to push with contractions. The nurse noted:

> Dr. Applewhite PE 7 cm, -1, 90%, having patient push
> with contractions, question doctor reason for pushing,
> states "to bring head down, it's a new thing."

Pushing with contractions prior to full dilation is contraindicated. Encouraging or directing a patient to push prior to full dilation is contrary to accepted standards of medical care. At 8:30

p.m. on November 9, 1995, examination by Respondent again showed 7 cm dilation. Respondent again directed the patient to push with contractions. (Ex. 5D, pp. 44, 47; T. 10/16/00 pp. 14-15.)

57. Patient D remained at 7 cm dilation for 5 hours from 3:10 p.m. to 8:30 p.m. Station of the vertex did not progress beyond -1. Pelvic examination by a nurse at 10:30 p.m. was documented as 7.5 cm and -1 station. A primigravida, such as Patient D, is expected to dilate at a rate of 1 cm per hour during the active phase of labor. A caesarean section is indicated after 2 hours without progress. Patient D did not progress for 5 hours. It does not appear that Respondent was present at the hospital between 2:20 p.m. and 8:30 p.m. From 2 p.m. to 2:50 p.m., fetal heart monitoring showed decreased variability with occasional accelerations. From 6 p.m. to 7:40 p.m., decreased variability was noted. At 9:19 p.m., a late deceleration was noted and variability became very poor. This persisted with variable decelerations until approximately 10:20 p.m. A caesarean section should have been ordered prior to 10:35 p.m. on November 10, 1995. (Ex. 5D, pp. 40-48; Ex. 5E; T. 10/16/00 pp. 15-20.)

CONCLUSION

Respondent's care and treatment of Patient D failed to meet acceptable standards of medica care, in that:

- Respondent failed to offer, obtain, and/or document genetic screening (alpha fetoprotein).

- Respondent failed to maintain records of prenatal office visits from October 4, 199 until admission to the hospital on November 9, 1995.

- Respondent failed to admit Patient D to the hospital on November 8, 1995.

- Respondent failed to obtain and/or record blood pressure measurements during an office visit on November 8, 1995.

- Respondent failed to perform and/or record urine testing for protein during an offic visit on November 8, 1995.

- During labor, Respondent failed to order and/or obtain adequate testing of deep ten reflexes.

- During labor, Respondent failed to order and/or obtain repeat urinalysis to evaluate proteinuria.

- Respondent failed to initiate magnesium sulfate therapy in a timely manner.

- Respondent failed to examine and evaluate Patient D from 2 p.m. on November 9, 1995, to approximately 3 p.m. on November 10, 1995.

- During labor, Respondent ordered, directed, and/or encouraged Patient D to push with contractions prior to full dilation.

- Respondent failed to order and/or perform a caesarean section in a timely manner.

PATIENT E

58. Respondent treated Patient E from on or about September 1, 1998, to on or about April 10, 1999, at her office and Millard Filmore Suburban Hospital. (Ex. 6A, Ex. 6B.)

59. Patient E was a white, 24 year-old woman with one previous live birth during this pregnancy. She was seen at Respondent's office on September 1, 1998, for possible pregnancy. Her first prenatal visit was on September 28, 1998. Diastolic blood pressure averaged 68 until 20 weeks of pregnancy and then 70-80 during the 20th to 29th week of pregnancy. (Ex. 6A, pp. 8.)

60. Patient E was seen at Respondent's office for a prenatal visit on February 22, 1999, at 31 weeks gestation. Blood pressure was 130/90. Urine was negative for protein. Uric acid was 3.9. Platelets were normal. (Ex. 6A, pp. 8, 53.)

61. Patient E was seen at Respondent's office for a prenatal visit on March 8, 1999. Blood pressure was 120/90. Urine was negative for protein. No further laboratory studies or evaluation were ordered. (Ex. 6A.)

62. Patient E was seen at Respondent's office for a prenatal visit on March 22, 1999, at 35 weeks gestation. Blood pressure was 140/100 and 130/98 on retest. Trace protein was found in the urine. Laboratory studies showed uric acid of 4.7. (Ex. 6A, pp. 8, 36.)

63. Patient E was seen at Respondent's office for a prenatal visit on March 29, 1999, at 36 weeks gestation. Blood pressure was 130/90. Urine was negative for protein. No laboratory studies or further evaluation was ordered. (Ex. 6A.)

64. Patient E was seen at Respondent's office on March 31, 1999, at 36 weeks gestation. Blood pressure was 120/70. Urine showed trace protein. No laboratory studies or other evaluation was ordered. (Ex. 6A.)

65. Patient E was seen at Respondent's office on April 5, 1999 at 37 weeks gestation. Immediate admission to the hospital was indicated to evaluate worsening PIH and for possible delivery. Blood pressure was 140/100. Urine showed 1+ protein. Arrangements were made for Patient E to be admitted to Millard Filmore Suburban Hospital for induction of labor on April 7, 1999 at 7 p.m. No testing or restrictions were ordered for the interim. (Ex. 6A, pp. 8, 13.)

66. During the last ten weeks of pregnancy, Patient E developed pregnancy induced hypertension. Serial fetal non-stress tests and/or biophysical profiles were indicated to evaluate fetal well being. They were neither ordered nor obtained. Complete laboratory studies to evaluate PIH including CBC with platelet count, uric acid, liver function tests and clotting studies were indicated to assess maternal well being. The laboratory studies described above were not complete nor frequent enough to provide sufficient information to evaluate pregnancy induced hypertension. Bed rest and low salt diet were not recommended as indicated. Antihypertension medication was indicated but was not prescribed. (Ex. 6A; T. 10/17/00 pp. 5-10.)

67. Patient E was admitted to the labor and delivery unit at Millard Filmore Suburban Hospital on April 7, 1999, at 7:30 p.m. Respondent admission note written the following day stated:

> "admitted for Cervidil induction secondary to mild toxemia, increased blood pressure, 1+ protein, 2+ edema, rising uric acid. Patient's due date is 4/27/99. During past 2 weeks blood pressure was noted to increase to 140/100. 2+ edema. Painful plantar aspects of feet. Previous pregnancy experienced similar type picture."

Blood pressure at admission was 146/79 and on repeat 130/87. Admission orders included a "Toxemia Panel" and intravaginal Cervidil to induce labor. (Ex. 6A, pp. 21, 26, 36.)

68. Cervidil was inserted at 9:20 p.m. on April 7, 1999. At 4:00-4:45 a.m., on April 8, 1999, a 6 minute late deceleration was noted. Respondent was notified. At 5:00 a.m. on April 8, 1999, fetal heart decelerations continued and the Cervidil was removed. Respondent was notified. The cervix was 1-2 cm dilated, 50 percent effaced and the vertex was at -2 station. (Ex. 6B, pp. 34-35, 51-52.)

69. At 6:35 a.m. on April 8, 1999, Respondent ordered Pitocin by telephone. Pitocin was administered by nursing personnel at 7:55 a.m. Prior to the ordering and administration of Pitocin, Respondent did not evaluate Patient E. The last pelvic examination was by a nurse and occurred 3 hours prior to initiation of Pitocin. Prior to and at initiation of Pitocin, the

physician should be present to personally evaluate the patient to assure both maternal and fetal safety. Respondent did not attend Patient E until 10:20 a.m., approximately two and a half hours after Pitocin was initiated. (Ex. 6B, pp. 23, 35-36, 48.)

70. Fourteen and a half hours after admission, Respondent examined Patient E at approximately 10:20 a.m. Artificial rupture of membranes was performed. Station of the presenting part was not documented. Pitocin was increased and Patient E progressed rapidly to an uneventful vaginal delivery of a 7 pound, 4 ounce male infant of Apgar scores of 9/9 at 12:38 p.m. (Ex. 6B, pp. 46-48, 54.)

71. After delivery, Patient E was transferred to a hospital room at 3:20 p.m. on April 8, 1999. In an untimed physician's order dated April 9, 1999, Respondent wrote "discharge home in a.m., office visit in 6 weeks." The physician progress notes and nurses notes do not document that Patient E was seen by a physician after delivery and prior to discharge. Patient E was discharged from the hospital at 11 a.m. on April 10, 1999. Postpartum patients should be evaluated by the attending physician prior to discharge. (Ex. 6B, pp. 23, 36-37, 69-73; T. 10/17/95 pp. 14-17.)

CONCLUSIONS

Respondent's care and treatment of Patient E failed to meet acceptable standard of medical care, in that:

- Respondent failed to order and/or obtain fetal non stress tests and/or biophysical profiles during the last ten weeks of pregnancy.

- Respondent failed to order and/or obtain adequate laboratory studies to evaluate PIH during pregnancy.

- Respondent failed to adequately attend Patient E during labor.

- Respondent failed to attend, examine, and or evaluate Patient E on April 10, 1999, the day of discharge.

PATIENT F

72. Respondent treated Patient F from on or about June 26, 1997, to on or about January 31, 1998. During the pregnancy in question, Patient F was a 25 year-old white female primigravida. (Ex. 7A, 7B.)

73. Patient F was first seen for this pregnancy on June 27, 1997, when initial laboratory studies were ordered. She was next seen on July 11, 1997, at 8-9 weeks of pregnancy. At neither office visit was an appropriate and complete physical examination performed or documented. (Ex. 7A, pp. 17-18; T. 10/17/00 pp. 104-108.)

74. Patient F was seen at Respondent's office on fourteen occasions between July 11, 1997, and June 27, 1998, for prenatal visits. Although not documented in the office nursing notes, urine was tested for protein at each prenatal office visit according to the prenatal evaluation record. In early pregnancy, blood pressures ranged from 110-120/60-80. Blood pressures on December 12 and December 16 were documented as 140/84 and 134/84, respectively. (Ex. 7A, pp. 10-16.)

75. Patient F was seen for a prenatal office visit on January 7, 1998, at 33 weeks gestation. She had gained thirty-four pounds from her documented normal weight. Blood pressure was 128/88. Patient F complained of swelling in her feet and hands, in particular her right foot and lower leg up to the knee. She complained of pain in her joints and occasional tingling of her fingers worsening over the past 2 days. Patient F reported a decrease in fetal movement

over the past few days. Based on the patients elevated blood pressure and complaints, an evaluation for pregnancy induced hypertension with complete laboratory studies and biophysical profile should have been ordered and obtained. No laboratory studies or fetal surveillance was ordered. Respondent arranged for Patient F to be seen by Lisette D'Eon, M.D., for evaluation of unilateral joint swelling. (Ex. 7A, pp. 10-16; T. 10/17/00 pp. 108-110.)

76. Patient F was seen by Dr. D'Eon on January 13, 1998. Blood pressure was 142/92 sitting and 140/99 on her left side. Dr. D'Eon performed appropriate history and physical, diagnosed pregnancy induced hypertension, ordered appropriate laboratory studies and recommended bed rest.

77. Patient F was seen for prenatal office visit on January 13, 1998, at 34 weeks gestation. She had now gained forty pounds during pregnancy. Blood pressure was 140/88. Urine was negative for protein. A biophysical profile ordered that day and performed January 15 was normal. (Ex. 7A, pp. 15, 18, 51.)

78. A prenatal office visit scheduled for January 23, 1998, was canceled by the patient. Documentation by Respondent on page 2 of the prenatal evaluation form in her office record of an office visit on this date is false. (Ex. 7A, pp. 16, 18.)

79. Patient F was seen for a prenatal office visit at Respondent's office on January 27, 1998, at 36 weeks gestation. She had gained 9 pounds in the previous 2 weeks. Blood pressure was

176/98. 2+ protein was found in the urine. Patient F complained of headaches and dizziness. Deep tendon reflexes were not tested. Based on worsening PIH, admission to the hospital, magnesium sulfate to prevent seizures, and induction of labor were indicated. Respondent referred Patient F to Millard Filmore Suburban Hospital for outpatient evaluation to rule out toxemia. (Ex. 7A, pp. 16, 18; Ex. 7B, pp. 39.)

80. Patient F was seen as an outpatient at the Millard Filmore Suburban Hospital on January 27, 1998, at 5:45 p.m. by JoAnne Arnold, M.D., an unlicensed first year resident. Blood pressure was 141/88. Urinalysis showed 3+ protein. 2+ edema and 2+ deep tendon reflexes without clonus was noted. A non-stress test was reactive. Pelvic examination was deferred. Laboratory studies including uric acid, PTT and fibrinogen were normal. As stated previously, Patient F's condition warranted immediate admission to the hospital, magnesium sulfate, to prevent seizures, and induction of labor. After discussion between Dr. Arnold and Respondent, the patient was instructed to call if systolic blood pressure was greater than 150 or diastolic blood pressure was greater than 90, a biophysical profile was scheduled for the next day and the patient was sent home at approximately 7:15 p.m. Amniocentesis was scheduled for February 2, 1998. Patient F should have been fully evaluated by Respondent at the hospital prior to sending her home. (Ex. 7A, pp. 16; Ex. 7B, pp. 39; T. 120-134.)

81. On January 28, 1998, a biophysical profile was performed by Dr. Metzger. It was normal. Dr. Metzger noted blood pressure of 140/90 on the left side with 2+ proteinuria and complaints of headache and epigastric pain. Dr. Metzger recommended admission to the hospital for delivery. (Ex. 7A, pp. 49.)

82. Patient F was admitted to the Millard Filmore Suburban Hospital at 4 p.m. on January 28, 1998, with an admission diagnosis of preeclampsia. Labor was induced with Cervidil and progressed rapidly to delivery of a 5 pound, 2 ounce female at 1:15 a.m. on January 29, 1998 with Apgar scores of 7/8. Mother and baby were discharged from the hospital on January 31, 1998, in good condition. (Ex. 7B.)

CONCLUSIONS

Respondent's care and treatment of Patient F failed to meet acceptable standards of medi care, in that:

- Respondent failed to perform and/or record an adequate prenatal physical examin

- Respondent failed to order and/or obtain fetal non-stress tests and/or a biophysica profile on or about January 7, 1998.

- Respondent failed to test deep tendon reflexes on January 27, 1998.

- Respondent failed to admit Patient F to the hospital on January 27, 1998, for evaluation/treatment of PIH and possible delivery.

- Respondent failed to attend, examine and or evaluate Patient F at Millard Filmor Suburban Hospital on January 27, 1998.

PATIENT G

83. Respondent treated Patient G from on or about November 11, 1997, to on or about July 16, 1998, at her office and Millard Filmore Suburban Hospital. During this pregnancy Patient G was a white 27 year-old primigravida. (Ex. 8A.)

84. Patient G was seen at Respondent's office for prenatal visits on thirteen occasions between December 17, 1997 and July 8, 1998. Blood pressures were: 118/62, 104/68, 112/54, 132/58, 104/60, 118/68, 112/56, 132/64, 122/66, 122/68, 132/58, 122/64, and 126/68. Urine was negative for protein at each prenatal visit. 2+ edema was noted in the ankles and feet on June 10, 1998, at 35 weeks gestation. Pedal edema was noted to have decreased over the past week on June 24, 1998, at 37 weeks gestation. No edema was noted at the last 2 prenatal office visits on July 1 and July 8, 1998. Laboratory studies and serial fetal surveillance to evaluate pregnancy-induced hypertension were not ordered, nor were they indicated. Counseling regarding bed rest and salt restricted diet was not documented, offered, nor indicated. Patient G did not have signs or symptoms of pregnancy induced hypertension, mild or otherwise. (Ex. 8A, pp. 16; T. 1390-1392.)

85. Respondent admitted Patient G to Millard Fillmore Suburban Hospital on July 12, 1998, at 7 p.m. for induction of labor. Patient G was at term. Respondent ordered Cervidil induction of labor which began at 8 p.m. A Physician's progress note written by Respondent states "patient admitted for induction at term. Prenatal course benign." Blood pressure at admission was 140/76. Urine was not tested for protein. Contrary to the physician's progress note

written by Respondent, the nurses obstetric admitting record, countersigned by Respondent, lists the reason for admission as mild preeclampsia. Patient G's prenatal and hospital records contain no evidence of "mild preeclampsia" or pregnancy induced hypertension. (Ex. 8A; Ex. 8B, pp. 24, 31, 33.)

86. Induction of labor with prostaglandins like Cervidil is associated with an increased risk of hyperstimulation of the uterus causing fetal distress, rupture of the uterus, cesarean section, amnionitis, and postpartum hemorrhage due to uterine atony. There was no indication to induce labor for Patient G. (T. 1385-1390.)

87. Cervidil was inserted by a resident at 8 p.m. on July 12, 1998. The cervix was noted to be thick and the presenting part high. Respondent was not present. Patient G responded with vigorous contractions which came too close together by 9:40 p.m. Late decelerations occurred over the next thirty-five minutes. At 10:15 p.m., an IV was started and a bolus of fluid administered. Patient G was 2 cm dilated, 50 percent effaced, at -2 station. At 11:15 p.m., Patient G 3-4 cm dilated, 50 percent effaced, at -2 station. At 11:25 p.m., Respondent was called by the nurses and ordered removal of the Cervidil. At 12:40 a.m. on July 13, 1998, an epidural was administered by an anesthesiologist. There is no mention of preeclampsia/PIH in the anesthesia records. At 1:15 a.m., Patient G was 4 cm dilated, 70 percent effaced, at -2 station. The membranes ruptured spontaneously and light meconium stained fluid was noted. At 2:20 a.m., nurses notified Respondent by telephone of variable decelerations with late components. Respondent ordered continued observation. At 2:40 a.m., an internal lead was applied by a nurse. At 2:50 a.m., a resident was called to evaluate

the fetal heart rate pattern. The resident noted a fetal heart rate of 140-150 with moderate to severe variable decelerations and some late decelerations. Uterine hyperstimulation was diagnosed and Turbutaline was ordered. Respondent was called and asked to come to the hospital. At 3:30 a.m., 7 2 hours after induction of labor was initiated, Respondent examined Patient G and found that she was 7 cm dilated with the vertex high and not well applied to the cervix. Her plan was to continue observation, "may need to deliver abdominally if clinical conditions persist." At 3:50 a.m., Respondent found the patient was 8 cm dilated and the presenting part (vertex) remained high. Additional Turbutaline was ordered and administered. Respondent left the hospital. At 5:30 a.m., Patient G was 8 to 9 cm dilated, 90 percent effaced, and vertex was at -2. At 5:40 a.m., Respondent was called and informed of the vaginal examination, fetal heart pattern, and contraction pattern. A foley catheter was ordered and placed. At 3:00 a.m., fetal heart rate rose to 150 and was noted in the 160-175 range at 3:15 a.m. Fetal heart rate pattern continued to show variable decelerations with late components. At 6:30 a.m., the fetal heart rate dropped to the 70's, but responded to scalp stipulation. Patient G was 9 cm dilated, with the vertex at -1 to -2 station. Degree of effacement was not noted. At 6:45 a.m., Respondent was telephoned and informed of bradycardia. Respondent informed the nursing staff that she was on her way to the hospital. At 7:40 a.m., Respondent evaluated Patient G and noted 9 cm dilation with a high vertex. Respondent instructed Patient G to push with contractions. At 7:45 a.m., the patient was positioned on her hands and knees and encouraged to push with contractions. At 7:55 a.m., Respondent ordered a cesarean section. Patient G delivered a 8 pound 14 ounce male infant with Apgar scores of 7/9 at 8:39 a.m. on July 13, 1998. (Ex. 8B, pp. 33-36, 47-53, 97-187; T. 1393-1403.)

88. After placement of Cervidil at 8 p.m., Patient G developed rapid contractions and late decelerations. Respondent was not present to evaluate the progress of labor. At 11:25 p.m., Respondent was informed of the patient's condition but did not come to the hospital. At 1:15 a.m., membranes ruptured spontaneously and showed light meconium stained fluid. At 2:20 a.m., Respondent was notified of the continued rapid contraction pattern and variable decelerations with late component. Contractions were occurring as frequently as 9 times in ten minutes. At 3:00 a.m., the resident called Respondent as asked her to come to the hospital. She arrived at 3:30 a.m. At 3:50 a.m., the second dose of Turbutaline was administered by Respondent. Observation by the attending physician to determine whether Turbutaline slowed the contractions was warranted. Respondent was not present. Frequent contractions continued. Based on the fetal heart rate pattern, frequent contractions, lack of progress, and meconium stained amniotic fluid, a cesarean section was indicated prior to 7:55 a.m. (Ex. 8B; T. 1393-1403.)

89. On November 22, 1997, at 7 weeks gestation, the platelet count was normal at 180,000. At admission to the hospital on July 12, 1998, platelet count was low at 130,000. Two days later on July 14, 1998, the platelet count was 104,000. These laboratory values represent thromboctopenia (low platelet count) warranting further evaluation and/or consultation with a hematologist. (Ex. 8A, pp. 61; Ex. 8B, pp. 39; T. 1404-1407.)

CONCLUSIONS

Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

- Respondent ordered induction of labor without adequate medical justification.

- Respondent failed to adequately attend, examine, and/or evaluate Patient G during labor.

- Respondent failed to order and/or perform a cesarean section in a timely manner.

- Respondent failed to adequately evaluate thrombocytopenia.

PATIENT H

90. Respondent treated Patient H from on or about July 2, 1997 to on or about February 7, 1998, at her office and Millard Fillmore Suburban Hospital. During this pregnancy, Patient H was a 32 year-old white female with one previous pregnancy terminated by abortion. (Ex. 9A.)

91. Patient H was seen for prenatal visits at Respondent's office on twelve occasions between July 16, 1997, and February 3, 1998. Although not documented in the office nursing notes, urine was tested for protein at each prenatal office visit according to the prenatal evaluation record. Patient H was seen for a prenatal office visit by Respondent on January 14, 1998, at 33 weeks gestation. Blood pressure was 132/88. Urine showed trace protein. At previous prenatal office visits blood pressure was 120/70 on July 16, 1997, 108/60 on August 13, 126/78 on September 9, 100/70 on October 7, 102/70 on October 28, 108/70 on December 2, 108/68 on December 17, and 120/78 on December 31. (Ex. 9A, pp. 10-16.)

92. On January 28, 1998, Patient H was seen at Respondent's office for a prenatal visit at 35 weeks gestation. Blood pressure was 144/96. 1+ protein was noted in the urine. Patient H complained of occasional headaches. Laboratory studies showed a rising uric acid level. Patient H's condition warranted admission to the hospital for complete evaluation of pregnancy induced hypertension and possible delivery. Respondent instructed Patient H to return to the office in one week. (Ex. 9A, pp. 10-16; T. 1482-1485.)

93. Patient H returned to Respondent's office for a prenatal visit on February 3, 1998, at 36 weeks gestation. Blood pressure was 150/98. 1+ protein was found in the urine. Respondent instructed Patient H to return to the office in one week. (Ex. 9A, pp. 10-16.)

94. On February 4, 1998, Respondent scheduled Patient H for a non-stress test and biophysical profile with Laurel White, M.D. Dr. White found blood pressure of 140/100 on the left side. She noted that the patient's initial blood pressure was 120/70, that 1+ proteinuria and a uric acid level of 7.6 was found on January 28, 1998 at Respondent's office and that the patient complained of occasional headaches. Dr. White made Respondent aware that Patient H was taken to labor and delivery at Millard Filmore Suburban Hospital. (Ex. 9A, pp. 13, 51.)

95. Patient G was admitted to Millard Filmore Suburban Hospital on February 4, 1998, at 2:30 p.m. Blood pressure was 153/92. She was examined by a resident who noted a history of 3-4 weeks of swelling of the hands and one week of facial edema. Vaginal exam showed fingertip dilation, 70 percent effacement, and station -3. Deep tendon reflexes were 3+ and brisk. 2+ proteinuria was noted. (Ex. 9B, pp. 26-27.)

96. At 4 p.m., the resident noted that Respondent had been contacted by the nursing staff and did not want magnesium sulfate administered or toxemia protocol at that time. (Ex. 9B, pp. 27.)

97. Magnesium sulfate was indicated and should have been ordered by Respondent. (T. 1487-1489.)

98. At admission and shortly thereafter, Patient H's condition warranted evaluation by the attending physician to assure maternal and fetal well-being. Respondent did not attend Patient H until 11:40 a.m. on the following day, twenty-one hours after admission. (Ex. 9B, pp. 27-29, 38-49; T. 1489-1490.)

99. At 5:30 p.m. on February 4, 1998, the resident noted that deep tendon reflexes were 3+ and brisk. Admission laboratory studies had returned and were recorded in the chart. Abnormal values included 2+ proteinuria, elevated uric acid level of 7.5 and mildly elevated alk. phos. (139) and LDH (197). Cervidil was inserted. At 6:00 p.m. and 8:45 p.m., Respondent was notified of the patient's condition. At 11:30 p.m., deep tendon reflexes were noted as 2+. Patient H complained of a slight headache. Blood pressure was 114/80. At 3:00 a.m. on February 5, deep tendon reflexes were 2+ and blood pressure was 133/66. At 6:00 a.m., Pitocin was ordered. At 10:03 a.m., membranes ruptured spontaneously. At 10:55 a.m., Respondent was called and informed of the patient's status and that the patient needed an internal scalp electrode, that the patient was difficult to monitor, both fetal heart rate and contraction pattern. Respondent instructed the nurses to monitor the patient as best they could. At 11:10 a.m., Patient H was complaining of increased discomfort. At 11:12 a.m., Respondent was re-called by M. Herd, RN, the charge nurse to come to the hospital to evaluate her patient and possible intervention of internal scalp electrode and/or intrauterine pressure catheter. At 11:20 a.m., the charge nurse was in to see Patient H. A vaginal exam showed 3-4 cm dilation and station -1. Placement of an internal scalp electrode was attempted. Cervidil (previously documented as removed) was found and removed. Pitocin had been off. At 11:30 a.m., Respondent was noted to be on her way in. Respondent arrived

at 11:40 a.m. At 12:30 p.m., Respondent called the hospital and asked the nurses to perform a pelvic exam. Patient H was 4-5 cm dilated. At 4:40 p.m., Patient H was fully dilated and Respondent was informed by nursing staff. At 5:40 p.m., Respondent attended Patient H. At 6:11 p.m., Patient H delivered a 6 pound 4 ounce female infant with Apgar score of 9/9. Patient H's condition at admission and during labor warranted further and more frequent evaluation and monitoring by the attending physician. (Ex. 9B, pp. 38-49; T. 1489-1491.)

CONCLUSIONS

Respondent's care and treatment of Patient H failed to meet acceptable standards of medical care, in that:

- Respondent failed to admit Patient H to the hospital on January 28, 1998, for evaluation of PIH and possible delivery.

- Respondent failed to adequately attend, examine, and/or evaluate Patient H during labor.

- Respondent failed to order and/or administer magnesium sulfate.

PATIENT I

100. Respondent treated Patient I from on or about March 5, 1999, to on or about November 29, 1999, at her office and Millard Filmore Suburban Hospital. During this pregnancy, Patient I was a 35 year-old female with a history of 2 previous large (macrosomic) babies. (Ex. 10A.)

101. Patient I was seen for prenatal office visits on twelve occasions between May 7, 1999 and October 26, 1999. (Ex. 10A, pp. 32.)

102. An antibody screen is a standard prenatal laboratory evaluation used to evaluate the presence of antibodies in the mothers blood system. Every pregnant patient should have an antibody screen done at the first prenatal office visit. Respondent did not order, perform or obtain an antibody screen during this pregnancy. (Ex. 10A, pp. 33; T. 1544-1546.)

103. Patient I was seen at Respondent's office on July 7, 1999, at 24 weeks gestation by early ultrasound done March 25, 1999. Fundal height was recorded at 35 cm. A sonogram was indicated to evaluate the discrepancy between gestational age and fundal height and the possibility of macrosomia, fetal hydrops, hydrocephalus and/or missed twins. A sonogram was not ordered or obtained by Respondent. (Ex. 10A, pp. 32; T. 1548-1549.)

104. Patient I was seen at Respondent's office for a prenatal visit on October 12, 1999, at 38 weeks gestation. Blood pressure was 170/88. 1+ protein was noted in the urine. Diastolic blood pressures had previously ranged from 60 to 80. Laboratory studies to evaluate maternal well-

being and a non-stress test to evaluate fetal well-being were indicated. Neither was ordered. Patient I was instructed to return to Respondent's office for her next appointment on October 26, 1999. At 38 weeks gestation, patients should be seen weekly. Patients with recently elevated blood pressure and 1+ proteinuria should be seen within 2 or 3 days. (Ex. 10A, pp. 32; T. 148-151.)

105. On October 18, 1999, Respondent telephonically arranged for a non-stress test of Patient I the following day at 10:00 a.m. This test was normal. (Ex. 10, pp. 30, 45.)

106. Patient I was seen at Respondent's office for a prenatal visit on October 26, 1999, at 40 weeks gestation. At this office visit, Patient I signed a statement labeled "informed consent" stating that she had given Respondent "permission for induction of labor. I am at term and have gone past my due date. I am aware of the risks of induction, i.e. an increased risk of cesarean section. I am in agreement with this approach to delivery." At this date, Patient I was not past due by early ultrasound, the most reliable method for dating a pregnancy. Respondent's records document that the patient was at 40 weeks gestation. Respondent planned and made arrangements for induction of labor at Millard Filmore Suburban Hospital on October 28, 1999. (Ex. 10A, pp. 32, 152; Ex. 10B, pp. 32.)

107. Patient I was admitted to Millard Filmore Suburban Hospital at 6:45 a.m. on October 28, 1999 for planned induction of labor at 40 weeks, 2 days gestation. The nurses noted that Patient I lost her mucus plug at 5:00 a.m. that day. (Ex. 10B.)

108. Immediately after admission, the external fetal monitor demonstrated a drop in the fetal heart rate to 80. Amy Lindsley, CNM, was called to see the patient. Nurse Lindsley noted that the fetal heart rate increased to the 120's with scalp simulation, then decreased to the 90's and returned to the 120's - 130's over the next 2 minutes. Variability was average. On vaginal exam she noted the cervix was 3 cm dilated, 80 percent effaced and the station was -1. Membranes were felt. Respondent was notified of the patient's fetal heart rate, status on admission, and current status. Respondent was made aware that the patient was contracting and wanted to observe the patient's labor (hold Pitocin). (Ex. 10B, pp. 20-21, 32.)

109. At 7:50 a.m., Patient I was evaluated by C. Stack, CNM. Vaginal exam showed 3 cm dilation, 80 percent effacement, and station at -2. Artificial rupture of membranes was performed. Thick, particulate, pea soup, meconium stained amniotic fluid was noted. Respondent was notified and ordered amnioinfusion. Respondent did not respond to the hospital to evaluate Patient I. Amnioinfusion was started at 8:21 a.m. (Ex. 10B, pp. 21-22, 32.)

110. At 8:30 a.m., Patient I was evaluated by the nurse midwife. Coupling of contractions, decreased variability, and early decelerations were noted. Vaginal examination showed 3 cm dilation, 80 percent effacement and station at -3. Respondent was called and asked to see the patient. (Ex. 10B, pp. 22, 32.)

111. Respondent arrived at the hospital and evaluated Patient I as 9:45 a.m. She wrote a physician's progress note in the chart summarizing the patient's condition at and since admission. Respondent's plan was to continue to observe the patient, if fetal heart rate "remains reassuring" will augment labor with Pitocin, if "any signs of decompensation will require primary cesarean section." At 10:00 a.m., the nurses noted a verbal order from Respondent to begin Pitocin augmentation. Pitocin was initiated shortly after 10:00 a.m. (Ex. 10B, pp. 22, 32.)

112. At 10:25 a.m., a new scalp electrode was placed by nurse Stack. At 11:05 a.m., an epidural was placed. At 11:45 a.m., vaginal examination by the nurse showed 7-8 cm dilation, 80 percent effacement and station at -1/-2. Variable decelerations and average variability were

noted. Respondent was notified and requested to be called when the patient was fully dila (Ex. 10B, pp. 23, 32.)

113. At 12 noon, variable decelerations were noted. Respondent was notified and informed nursing staff that she was on her way. At 12:10 p.m., nursing notes document that Patient was 8 cm dilated and had the urge to push. At 12:15 p.m., Patient I was fully dilated and pushing with the nurse midwife in attendance. At 12:20 p.m., Pitocin was discontinued. Nurses notes document that "Dr. Applewhite on her way." At 12:25 p.m., Patient I was pushing with contractions. Pediatrics and nursing were notified regarding previous meco stained amniotic fluid. Variable decelerations were noted. Patient I was prepared for delivery. Nurses notes document "awaiting Dr. Applewhite." At 12:30 p.m., fetal heart r went from the 80's to 40-50 and the patient was crowning. Nurses noted "Dr. Applewhite At 12:32 p.m., Patient I delivered an 8 pound, 1 ounce male infant with Apgar scores of 6 A delivery note was written by a student physician's assistant at 1:00 p.m. (Ex. 10B, pp. 24, 32-34.)

114. Patient I's infant developed meconium aspiration syndrome and pulmonary hypertension. was transferred to the neonatal intensive care unit at Children's Hospital of Buffalo shortly after birth. (Ex. 10A, Ex. 10B.)

115. At 1:30 p.m. on October 28, 1999, one hour after delivery, nursing personnel received a telephone order from Respondent that Patient I should be discharged that evening if the patient desired and she was stable. At 5:00 p.m., four and a half hours after delivery, nurs personnel received a telephone order from Respondent that Patient I should be discharged

home the following morning with instructions to return to Respondent's office in 1 week. (Ex. 10B, pp. 14.)

116. Prior to discharge and at or about the time of discharge, postpartum patients should be evaluated by the attending physician. Respondent did not adequately evaluate Patient I prior to giving the above telephone orders for discharge. (Ex. 10B; T. 1558-1559.)

117. During labor, Patient I was a high-risk patient. At admission fetal heart was 80. She was notified. Thick pea soup meconium was noted when artificial rupture of membranes was performed. Respondent was notified. Fetal heart rate abnormalities were noted. Respondent was informed. Nursing personnel requested attendance by Respondent. One hour and 15 minutes later, Respondent arrived, stayed fifteen minutes and left the patient to the care of nursing personnel. Despite phone calls from the nursing staff, Respondent arrived, if at all, 2 minutes prior to delivery. Patient I's condition warranted further and more frequent evaluation by Respondent. (Ex. 10B; T. 1554-1558.)

CONCLUSIONS

Respondent's care and treatment of Patient I failed to meet acceptable standards of medical care, in that:

- Respondent failed to order and/or obtain an antibody screen during pregnancy.

- Respondent failed to order and/or obtain a sonogram on or about July 7, 1999.

- Respondent failed to order and/or obtain a non-stress test on or about October 12, 1999.

- Respondent failed to adequately evaluate and/or monitor pregnancy between October 12, 1999 and October 26, 1999.

- Respondent ordered induction of labor without adequate medical justification.

- Respondent failed to adequately attend, examine, and/or evaluate Patient I during labor.

- Respondent attempted to discharge Patient I from the hospital without adequate evaluation.

COBRA VIOLATION

118. On September 22, 1998, the Office of Inspection General, United States Department of Health and Human Services, informed Respondent of its determination that she violated Section 1867 of the Social Security Act (COBRA Violation) by transferring a pregnancy patient from Mercy Hospital of Buffalo to Children's Hospital of Buffalo (CHOB) without certifying that the benefits outweighed the risks, without a physician's examination of the patient, without providing for a safe transfer, without contacting CHOB to request a transfer or to advise CHOB that the patient would be arriving at their hospital, and without obtaining the agreement of CHOB to accept the patient. On August 23, 1999, Respondent entered into a settlement agreement with the Office of Inspector General, United States Department of Health and Human Services and agreed to pay a civil monetary penalty of $45,000. (Ex. 11.)

PRELIMINARY ISSUES

This case started on June 29, 2000 with an Order of Summary Suspension of Respondent's license to practice medicine by the Commissioner of Health. The Respondent has waived the right to object to any failure of the State to complete these proceedings within the statutory time limit (T. p. 29). It appears that the 90-day time limit limitation for completion of a Summary Suspension case was enacted for the protection of respondents in general so that the issue of alleged egregious misconduct should be promptly tried at an early hearing to avoid irreparable harm to a respondent who may not practice in the interim.

That scenario did not occur in this case. The Administrative Officer was assigned in June of 2000. Trial days with Respondent's first attorney was scheduled for July 2000. Then Respondent changed attorneys after waiving her right to a speedy trial. Attorney Tarantino appeared on August 21, 2000. The attorneys agreed that because of the long list of patient cases that the issue of "imminent danger" would be tried concurrently with the proceedings for professional misconduct (pre-trial transcript p. 20).

Already, almost two months had expired since the suspension. At the pre-trial conference (8/25/00) Mr. Tarantino made the first of several announcements about his busy trial calendar (pre-hearing transcript p. 31) although he did acquiesce to the three dates previously set with the prior attorney (9/19, 10/2 and 10/3). Thus, the 90 day time limit (9/29/00) was surpassed after only 1 day (9/19/00) of a hearing which ultimately required 15 hearing days and at that, was intentionally abbreviated by the failure of the Respondent to testify regarding 6 of the 8 patient cases, and further abbreviated by the failure of the Respondent's expert to return for completion of his cross-examination by the State. The last hearing date was 11/09/01, more than 16 months after the

suspension. Briefs were set for early December and two December deliberation days were set asid In December, counsel for the State asked for an extension of the time to file a brief because of illn which was granted until a date in late January. Respondent's counsel did not prepare a final writte brief. Deliberations were held on 2/14/02, whereupon this Determination was reached on the char

Because of the very unusual delay on this case, caused mostly by Mr. Tarantino's trial calendar; and the complete acquiescence of the Respondent to the delay without any comment or objection whatsoever; and in light of the Determination made by the Committee in this case; this Committee need not rule on the issue of imminent danger. There is, at this point, no reason to mak distinction on the evidence between "imminent danger" and "professional misconduct" since the o apparent reason to do so is to provide the Respondent with a speedy hearing on the issue of the Summary Suspension. Respondent has waived her rights to a speedy hearing on the suspension, a is directly responsible for the extra 10 to 12 months of the almost 20 months which have elapsed since the suspension. Therefore, the issue of the summary suspension is MOOT.

Preliminary Issue 2:

There is no testimony or argument from the State regarding Patient C. Thus, any and all specifications dealing with Patient C and underlying factual allegations are not sustained.

DISCUSSION

The testimony of Robert Smith, M.D., the expert for the State, was eminently credible, articulated in a clear and concise manner, without the unpleasant edge of conceit which sometimes accompanies expert testimony. Although his expectations, made in hindsight, were sometimes inordinately high and some assumptions unrealistic, his testimony was very convincing overall. D

Smith carefully and expertly explained the reasons for his opinions. He did not waiver or change during an often FIERCE cross-examination. He was vehemently challenged by defense counsel on many details of each case, but he so well demonstrated his familiarity with the facts on which he based his opinion and his professional knowledge that his credibility was enhanced rather than diminished by the cross-examination. In that cross-examination of Dr. Smith and in his oral closing, defense counsel chose to emphasize the issue of "imminent danger" by dwelling most on the outcomes of each case. In each case of a negative outcome (Patients A and B) the suggestion was that Respondent's care was not the cause of death or that the patient could not have been saved by anyone because of unforeseen complications. On the remainder of the cases, the birth of a healthy baby was advanced for the argument that "all's well that ends well". To argue that none of the factual allegations, even when proved, amounted to a risk of "imminent danger" failed to sufficiently address the issues of professional misconduct. Suffice it to say that only a very few minor points of Dr. Smith's testimony were challenged successfully on cross-examination. The supreme effort of Respondent's counsel to distract and confuse the witness and the Panel were not successful. The testimony of Dr. Smith survived intact on the most important issues and provided the basis for this Determination beyond a preponderance.

Although some of the factual allegations which were established were stronger than others, the determination in this case rests on the big picture: An evaluation of Respondent's care of eight patients, which suggests a definite pattern of carelessness, neglect and lack of appreciation of obvious diagnostic indicators. A basic problem seems that the Respondent failed to sense impending danger and thus did not intervene to deflect it. She failed to appear at her patient's bedside even when told of suspicious signs and she rarely appeared for the sake of vigilance and concern. She is all too willing to rely on others to care for her patients while in the hospital, when the ultimate responsibility for the

patient is hers alone. She is careful enough to order consults but fails to properly evaluate the advice in her treatment regimens. She is a solo practitioner in a very complicated, risky area of medicine. It appears that she has no close colleagues to call on for comfort, unofficial advice or coverage. This seems a very unusual situation in itself because it shows a basic lack of understanding of the risks involved in going it alone. She was not professionally sharp, sufficiently attentive to her patients, nor adequately concerned about their welfare to be within minimum standards of care.

The COBRA charge (Paragraph J of the Charges) found in Exhibit 11 was based on a finding of SUBSTANTIAL CULPABILITY by the Office of Inspector General of the U.S. Department of Health and Human Services relating to an incident which occurred in 1995 at Mercy Hospital. As a part of that finding, there was reference to a troublesome track record while Respondent was on call at Mercy Hospital which involved "other incidents" where the Respondent failed to come to the hospital or to provide coverage when paid to do so, resulting in a 30 day suspension from Mercy Hospital in 1993.

This suspension should have been a wake-up call to the Respondent. However, carelessness continued, leading to a $45,000 fine for failing to come to the hospital in 1995 to treat a pregnant patient who appeared in the ER with contractions. Notwithstanding this substantial penalty, the carelessness continued through at least 1999. The Respondent failed to change her ways, to improve her performance and to demonstrate an attitude of excellence in the pursuit of her practice.

The final circumstance which adds great weight to the global evaluation of this case is Respondent's complete lack of remorse or admission of any guilt. She has not acknowledged any error in her care nor taken responsibility for any of the significant failures.

Respondent's defense was ineffective to nearly non-existent. On the witness stand, the Respondent seemed earnest and sincere at times but her testimony was not probitive or convincing.

She continued the lie told in her interview with the OPMC investigator regarding two sets of charts (T. 7/11/01, pp. 217-225). She did admit that she made a mistake in the alleged use of the letter "A" on prenatal charts to mean acetone, which notion was finally corrected, after several years of practice, by her expert witness, Dr. Howard, who told her that "A" always stood for albumin (T. 7/11/01, p. 198). Respondent's explanation that "A" means acetone in that context is so clearly an erroneous understanding of a simple basic standard ("A" always means albumin) as to illustrate gross incompetence or it is a preposterous falsehood.

As requested by counsel for the State, the Panel was instructed that a negative inference could be drawn from Respondent's failure to testify about Patient D through I. The obvious reason for that failure was that she did not hold up well under cross-examination, although other excuses were offered. Also significant was the fact that Respondent never admitted to an error. Indeed, it is the duty of the State to prove charges but, to those who must sit in judgment, some sign of recognition of a mistake or remorse is very persuasive, at times, at least on the issue of penalty, to bolster one's credibility.

The only witness called by the Respondent was Dr. James T. Howard. The Committee did not find him to be as knowledgeable or as credible as Dr. Smith. He took few opportunities to explain his position, and his answers were mostly simple "chapter and verse" as he was led through the script by counsel. Furthermore, he chose to editorialize a bit about his opinion on the disciplinary process itself by saying: "I think it's very, very prejudicial against the physician and I think this is an almost "Spanish Inquisition" kind of thing. . ." (T. 5/4/01, p. 66, L15). This remark shows such a bias as to make his entire testimony a nullity. As if this were not sufficient to discredit him, the testimony of Dr. Howard is a nullity as a matter of law because he failed to return for the conclusion of his cross-examination by the State (T. 7/12/01, p. 122).

The conclusion of the Committee is that the Respondent is a careless, dangerous physician which finding was evident in all eight cases. Whether or not the degree of deviation from the standard has been "egregious" in each and every case or in each and every factual allegation, the Committee finds that her persistent carelessness is an egregious situation. The Respondent's patients are in danger.

DETERMINATION OF THE HEARING COMMITTEE

Addressing the Specifications, Dr. Smith opined that Respondent's care of Patient A was a "significant deviation" from the standard of care (T. p. 69-70); and regarding Patient B, Dr. Smith found an "egregious" deviation. (T. p. 310-312); and in the case of Patient D, a "significant deviation" (T. 10/16/00, p. 21). The expert's opinion clearly included both competency and prudence, thus supporting Specifications 1, 2 and 4, gross negligence; and Specifications 10, 11 and 13, gross incompetence. The evidence did not support a finding of "gross misconduct" in the five remaining patient cases, although each case involved sub-standard care.

Having found support for three cases of gross negligence and three cases of gross incompetence, Specifications 19 and 20 must be sustained as a matter of law as included therein. In addition, as discussed above, there was evidence to support a finding of simple negligence in all 8 patient cases. This consistent pattern of negligence would constitute a sufficiently "egregious" situation in itself to support a revocation.

Specifications 21 and 22 relating to two sets of charts and the alteration of same are sustained based on a preponderance. The documentary evidence together with Respondent's inability to explain the discrepancies in any credible manner support the conclusion that allegation B.19 is more

likely true than not. Furthermore, it is more likely than not that Respondent's explanation was one lie trying to cover another.

Finally, Specification 23 was based upon a finding by a federal administrative body of "substantial culpability" for a "dumping" incident which occurred in 1995. The penalty of $45,000 was also quite substantial and Respondent agreed to the disposition of the case. This incident was clearly an instance of serious "professional misconduct" under the laws of New York State.

After a review of the entire record of this case the Hearing Committee determines that the Respondent's license to practice medicine should be **REVOKED**.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous)

FIRST through NINTH Specifications: (GROSS INCOMPETENCE)

1 SUSTAINED

2 SUSTAINED

3 NOT SUSTAINED

4 SUSTAINED

5 NOT SUSTAINED

6 NOT SUSTAINED

7 NOT SUSTAINED

8 NOT SUSTAINED

9 NOT SUSTAINED

TENTH through EIGTEENTH Specifications: (GROSS INCOMPETENCE)

10 SUSTAINED

11 SUSTAINED

12 NOT SUSTAINED

13 SUSTAINED

14 NOT SUSTAINED

15 NOT SUSTAINED

16 NOT SUSTAINED

17 NOT SUSTAINED

18 NOT SUSTAINED

NINETEENTH Specifications: (NEGLIGENCE ON MORE THAN ONE OCCASION)

19 SUSTAINED

TWENTIETH Specification: (INCOMPETENCE ON MORE THAN ONE OCCASION)

20 SUSTAINED

TWENTY-FIRST Specification: (FRAUD)

21 SUSTAINED

TWENTY-SECOND Specification: (MORAL UNFITNESS)

22 SUSTAINED

TWENTY-THIRD Specification: (ADMINISTRATIVE PROCEEDING)

23 SUSTAINED

ORDER

IT IS HERBY ORDERED THAT:

1. Respondent's license to practice medicine in New York is hereby **REVOKED**.

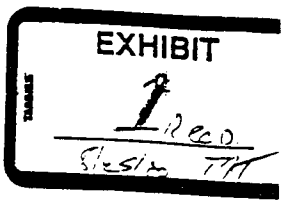
2. The ORDER shall be effective upon service on the Respondent or the Respondent's attorney by personal service or registered mail.

DATED: New York, New York
3/23/, 2002

LEMUEL ROGERS, JR., M.D.
Chairperson

RUFUS A. NICHOLS, M.D.
STEPHEN E. WEAR, Ph.D.

APPENDIX I



STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER : COMMISSIONER'S
OF : ORDER AND
MONICA J. APPLEWHITE, M.D. : NOTICE OF HEARING
----------X

TO: Monica J. Applewhite, M.D.
5820 Main Street
Williamsville, NY 14221

The undersigned, Antonia C. Novello, M.D., M.P.H., Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Monica J. Applewhite, the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12), that effective immediately Monica J. Applewhite, Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional

conduct of the State Board for Professional Medical Conduct on the 10th and 17th days of July, 2000 at 10:00 a.m. at Airport Radisson, 4243 Genesee Street, Buffalo, NY 14225 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180 (518-402-0751), 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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 or sanction 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 FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
June 29, 2000

ANTONIA C. NOVELLO, M.D., M.P.H.
Commissioner

Inquiries should be directed to:

KEVIN C. ROE
Associate Counsel
NYS Department of Health
Division of Legal Affairs
2509 Corning Tower
Albany, New York 12237-0032
(518) 486-1841

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
MONICA J. APPLEWHITE, M.D.	:	CHARGES

----------X

MONICA J. APPLEWHITE, M.D., Respondent, was authorized to practice medicine in New York State on October 14, 1986, by the issuance of license number 168151.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached appendix) from on or about May 12, 1999, until her death on June 3, 1999, at her office, 5820 Main Street, Williamsville, New York 14221 and Millard Fillmore Hospital, 1540 Maple Ave, Williamsville, New York. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to confirm that a previous pap smear was normal.
2. Respondent failed to order and/or obtain a cervical culture for gonorrhea and chlamydia testing.
3. Respondent failed to review May 19, 1999 laboratory reports in a timely manner.
4. Respondent failed to order and/or administer

adequate pre-operative antibiotic therapy.

5. Respondent performed elective surgery (tubal ligation and multiple myomectomies) through an infected surgical field.

6. Respondent failed to order and/or obtain internal medicine and/or hematology consultations in a timely manner.

B. Respondent treated Patient B from on or about June 19, 1998, until her death on February 5, 1999, at her office and Millard Fillmore Hospital. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to follow up on a historical report of possible tuberculosis.

2. Respondent failed to order and/or obtain HIV tests.

3. Respondent failed to order and/or obtain fasting blood sugar testing on or about June 26, 1998.

4. Respondent failed to obtain a glucose tolerance test in a timely manner prior to September 3, 1998.

5. Respondent failed to adequately monitor blood sugar levels from October 6, 1998 to admission.

6. Respondent failed to order and/or obtain an ultrasound on or about October 9, 1998, or in a timely manner thereafter.

7. Respondent failed to obtain a biophysical profile on December 18, 1998, or in a timely manner prior to

December 22, 1998.

8. Respondent failed to hospitalize Patient B for evaluation of pregnancy induced hypertension (PIH) and possible delivery on or about December 23, 1998.

9. Respondent failed to order and/or obtain fetal non-stress tests and/or biophysical profiles on or about December 23, 1998.

10. Respondent failed to obtain appropriate laboratory studies to evaluate the patient's worsening PIH on or about December 23, 1998.

11. Respondent failed to order fasting blood sugar test if acetonuria was present on December 30, 1998.

12. Respondent failed to order and/or obtain non-stress tests and/or biophysical profiles on or about December 30, 1998.

13. Respondent failed to obtain appropriate laboratory studies to evaluate the patient's worsening PIH on or about December 30, 1998.

14. Respondent failed to admit Patient B to the hospital in a timely manner on or after December 30, 1998.

15. Respondent failed to order appropriate laboratory studies at admission.

16. Respondent failed to adequately attend Patient B post partum.

17. Respondent failed to adequately evaluate, diagnose and/or treat post-partum PIH.

18. Respondent failed to adequately evaluate, diagnose and treat HELLP syndrome.

19. Respondent falsely altered her office medical record by creating a second set of progress notes and by falsely altering other entries.

C. Respondent treated Patient C from on or about October 9, 1995, to on or about May 14, 1996, at her office and Millard Fillmore Hospital. Responded's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent performed artificial rupture of membranes at her office without adequate medical justification and despite contraindication.
2. Respondent failed to adequately examine and evaluate Patient C in the period of time immediately before and after artificial rupture of membranes.
3. Respondent failed to attend, examine, and evaluate Patient C in a timely manner after admission to the hospital.

D. Respondent treated Patient D from on or about April 14, 1995, to on or about November 14, 1995, at her office and Millard Fillmore Hospital. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to offer, obtain, and/or document

genetic screening (alpha fetoprotein).

2. Respondent failed to maintain records of prenatal office visits from October 4, 1995, until admission to the hospital on November 9, 1995.

3. Respondent failed to admit Patient D to the hospital on November 8, 1995.

4. Respondent failed to obtain and/or record blood pressure measurements during an office visit on November 8, 1995.

5. Respondent failed to perform and/or record urine test for protein during an office visit on November 8, 1995.

6. At admission to Millard Fillmore Hospital on November 9, 1995, Respondent failed to test deep tendon reflexes.

7. At admission to Millard Fillmore Hospital on November 9, 1995, Respondent failed to perform a pelvic examination.

8. During labor, Respondent failed to order and/or obtain adequate testing of deep tendon reflexes.

9. During labor, Respondent failed to order and/or obtain repeat urinalysis to evaluate proteinuria.

10. Respondent failed to initiate magnesium sulfate therapy in a timely manner.

11. Respondent failed to examine and evaluate Patient D after admission to Millard Fillmore Hospital ~~on~~ FROM November 9, 1995, at approximately ~~9:30 a.m.~~ 2:00 P.M., until approximately 3:10 p.m. on November 10, 1995.

12. During labor, Respondent ordered, directed, and/or encouraged Patient D to push with contractions prior to full dilation.

13. Respondent failed to order and/or perform a caesarean section in a timely manner.

E. Respondent treated Patient E from on or about September 1, 1998, to on or about April 10, 1999, at her office and Millard Fillmore Hospital. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order and/or obtain fetal non-stress tests and/or biophysical profiles during the last 10 weeks of pregnancy.
2. Respondent failed to test deep tendon reflexes during the last 10 weeks of pregnancy.
3. Respondent failed to order and/or obtain adequate laboratory studies to evaluate PIH during pregnancy.
4. Respondent failed to initiate antihypretension medication during pregnancy.
5. Respondent failed to adequately attend Patient E during labor.
6. Respondent failed to examine Patient E prior to ordering initiation of Pitocin.
7. Respondent failed to attend, examine, and/or evaluate Patient E on April 10, 1999, the day of discharge.

F. Respondent treated Patient F from on or about June 26, 1997, to on or about January 31, 1998. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent failed to perform and/or record an adequate initial prenatal physical examination.
2. Respondent failed to test urine for the presence of protein on every pre-natal office visit.
3. Respondent failed to order and/or obtain fetal non-stress tests and/or biophysical profiles on or about January 7, 1998.
4. Respondent failed to test deep tendon reflexes on January 27, 1998.
5. Respondent failed to admit Patient F to the hospital on January 27, 1998, for evaluation/treatment of PIH and possible delivery.
6. Respondent failed to attend, examine, and/or evaluate Patient F at Millard Fillmore Hospital on January 27, 1998.

G. Respondent treated Patient G from on or about November 11, 1997, to on or about July 16, 1998, at her office and Millard Fillmore Hospital. Respondent's care and treatment of Patient G failed to meet acceptable standards of care, in that:

1. Respondent ordered induction of labor without adequate medical justification.
2. Respondent failed to adequately attend, examine, and/or evaluate Patient G during labor.
3. Respondent failed to order and/or perform a cesarian section in a timely manner.
4. Respondent failed to adequately evaluate thrombocytopenia.

H. Respondent treated Patient H from on or about July 2, 1997, to on or about February 7, 1998, at her office and Millard Fillmore Hospital. Respondent's care and treatment of Patient G failed to meet acceptable standards of care, in that:

1. Respondent failed to test urine for the presence of protein at each pre-natal office visit.
2. Respondent failed to admit Patient H to the hospital on January 28, 1998, for evaluation of PIH and possible delivery.
3. Respondent failed to adequately attend, examine, and/or evaluate Patient H during labor.
4. Respondent failed to order and/ administer magnesium sulfate.

I. Respondent treated Patient I from on or about March 5, 1999, to on or about November 29, 1999, at her office and

Millard Fillmore Hospital. Respondent's care and treatment of Patient G failed to meet acceptable standards of care, in that:

1. Respondent failed to order and/or an obtain an antibody screen during pregnancy.
2. Respondent failed to order and/or obtain alpha fetoprotein tests and/or genetic amniocentesis during pregnancy.
3. Respondent failed to order and/or obtain a sonogram on or about ~~September~~ JULY 7, 1999.
4. Respondent failed to order and/or obtain a nonstress test on or about October 12, 1999.
5. Respondent failed to adequately evaluate and/or monitor pregnancy between October 12, 1999 and October 26, 1999.
6. Repondent ordered induction of labor without adequate medical justification.
7. Respondent failed to adequately attend, examine, and/or evaluate Patient I during labor.
8. Respondent attempted to discharge Patient I from the hospital without adequate evaluation.

J. On September 22, 1998, the Office of Inspector General, United States Department of Health and Human Services, informed Respondent of its determination that she violated Section 1867 of the Social Security Act (COBRA violation) by transferring a pregnant woman from Mercy

Hospital of Buffalo to Children's Hospital of Buffalo (CHOB) without certifying that the benefits outweighed the risks, without a physician's examination of the patient, without providing for a safe transfer, without contacting CHOB to request a transfer or to advise CHOB that the patient would be arriving at their hospital, and without obtaining the agreement of CHOB to accept the patient. On August 23, 1999, Respondent entered into a settlement agreement with Office of Inspector General, United States Department of Health and Human Services and agreed to pay a civil monetary penalty of $45,000.00.

SPECIFICATIONS

FIRST THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.

2. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14, B.15, B.16, B.17, B.18, and/or B.19.

3. The facts in Paragraphs C and C.1, C.2, and/or C.3.

4. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, and/or D.12.

5. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, and/or E.7.

6. The facts in Paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

7. The facts in Paragraphs G and G.1, G.2, G.3, and/or G.4.

8. The facts in Paragraphs H and H.1, H.2, H.3, and/or H.4.

9. The facts in Paragraphs I and I.1, I.2, I.3, I.4, I.5, I.6, I.7, and/or I.8.

TENTH THROUGH EIGHTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence on a particular occasion in violation of New York Education Law §6530(6), in that Petitioner charges:

10. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, and/or A.6.

11. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14, B.15, B.16, B.17, B.18, and/or B.19.

12. The facts in Paragraphs C and C.1, C.2, and/or C.3.

13. The facts in Paragraphs D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, and/or D.12.

14. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, and/or E.7.

15. The facts in Paragraphs F and F.1, F.2, F.3, F.4, F.5, and/or F.6.

16. The facts in Paragraphs G and G.1, G.2, G.3, and/or G.4.

17. The facts in Paragraphs H and H.1, H.2, H.3, and/or H.4.

18. The facts in Paragraphs I and I.1, I.2, I.3, I.4, I.5, I.6, I.7, and/or I.8.

NINETEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges two or more of the following:

19. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.6; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14, B.15, B.16, B.17, B.18, B.19; C and C.1, C.2, C.3; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12; E and E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4; H and H.1, H.2, H.3, H.4; and/or I and I.1, I.2, I.3, I.4, I.5, I,6, I.7, I.8.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

20. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.6; B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, B.13, B.14, B.15, B.16, B.17, B.18, B.19; C and C.1, C.2, C.3; D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, D.10, D.11, D.12; E and E.1, E.2, E.3, E.4, E.5, E.6, E.7; F and F.1, F.2, F.3, F.4, F.5, F.6; G and G.1, G.2, G.3, G.4; H and H.1, H.2, H.3, H.4; and/or I and I.1, I.2, I.3, I.4, I.5, I,6, I.7, I.8.

TWENTY-FIRST SPECIFICATION

FRAUD

Respondent is charged with practicing the profession

fraudulently in violation of New York Education Law §6530(2), in that Petitioner charges:

21. The facts in Paragraphs B and B.19.

TWENTY-SECOND SPECIFICATION

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20), in that Petitioner charges:

22. The facts in Paragraphs B and B.19.

TWENTY-THIRD SPECIFICATION

ADMINISTRATIVE PROCEEDING

Respondent is charged with resolving an adjudicatory proceeding regarding a violation of federal statute by stipulation or agreement when the violation of federal law would constitute professional misconduct under the laws of New York state in violation of New York Education Law §6530(9)(c), in that Petitioner charges the facts in Paragraph J.

DATED: June 27, 2000
Albany, New York

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