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

Public

Dennis P. Whalen
Executive Deputy Commissioner

October 28, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Radoslav Maric, M.D.
P.O. Box 656
Ansonia, Connecticut 06401

Radoslav Maric, M.D.
c/o Kreso Maric
Fraterscica 49
Zagreb, Croatia 10000

Leni S. Klaimitz, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Division of Legal Affairs
90 Church Street – 4th Floor
New York, New York 10001

RE: In the Matter of Radoslzav Maric, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-241) 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.

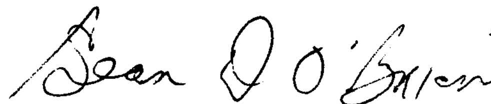
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER OF RADOSLAV MARIC, M.D.	DETERMINATION AND ORDER BPMC # 05- 0241

A Notice of Hearing and Statement of Charges, dated March 30, 2005, were served upon the Respondent, **RADISLAV MARIC, M.D. WILLIAM P. DILLON, M.D.**, Chairperson, **RAVINDER MAMTANI, M.D.**, and **MR. CHARLES AHLERS**, 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. **JEFFREY ARMON, ESQ.** served as Administrative Law Judge for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges :	April 1, 2005
Pre-Hearing Conference :	April 25, 2005
Hearing Dates:	May 3, 17, June 14, 21 and July 12, 2005
Department of Health appeared by:	DONALD P. BERENS, JR., ESQ., General Counsel, New York State Department of Health BY: **LENI S. KLAIMITZ, ESQ.**, of counsel
Respondent appeared :	**PRO SE**
Witnesses for Department of Health:	John C. Wirth, III, M.D. Susan Cannizaro, R.N. Nurse I Nurse J Dr. H

Witnesses for Respondent:	Maureen Muglia Levinson, R.N. Caroline Schulman, R.N. Radislav Maric, M.D. (Respondent)
Receipt of Submissions (Close of Record):	August 12, 2005
Deliberations held:	August 23, 2005

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for certain types of professional misconduct.

The following definitions were relied upon by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

Conclusions of law were made pursuant to the Findings of Fact listed below. Unless

otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee. A copy of the Statement of Charges (Ex. 1) is attached hereto as Appendix I.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T. = Transcript

AMENDMENTS TO THE STATEMENT OF CHARGES

During the course of this proceeding, the Department was granted leave to amend the Statement of Charges as follows:

1. Factual Allegation B.1. was amended to include the allegation that Respondent failed to appropriately address positive findings of a sexually transmitted disease.

2. Factual Allegation G was amended to delete reference to Respondent's alleged inappropriate conduct toward Dr. G.

3. Factual Allegation H amended the date of Respondent's alleged inappropriate actions to be June 28, 2000.

GENERAL FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on April 27, 1987 by the issuance of license number 169925 by the New York State Education Department. (Ex. 3)

FINDINGS RELATED TO PATIENT A

2. Respondent provided prenatal care to Patient A. The patient had given birth once previously and was at approximately thirty-eight weeks gestation on November 26, 1998. (Ex. 4, p. 20; T. 20, 447-449)

3. On November 26, 1998 (Thanksgiving Day), Patient A contacted Respondent on his cellular telephone and indicated that she was hemorrhaging and experiencing pain. Respondent was northeast of Bridgeport, Connecticut when he received the call. Following the telephone call the patient went to South Nassau Communities Hospital Center (SNCHC) in Oceanside, New York, on the south shore of Long Island. (Ex. 4; T. 276, 450-451, 462)

4. Shortly before or after Patient A presented at SNCHC, nurses at the labor and delivery room learned Respondent was in Connecticut and that it would take at least one hour for him to get to the hospital. During a telephone call while Respondent was in Connecticut, he instructed the nurses to call the closest physician. Respondent informed Nurse Susan Cannizzaro, R.N. that he had not arranged for coverage at SNCHC and had therefore directed Patient A to go to Long Island Jewish Hospital where residents could deliver her baby. (Ex. 4, p.59; T. 274-275, 468, 695, 697, 699, 720)

5. Patient A was admitted to the hospital at approximately 5:00 pm. Monitoring of Patient A and her fetus began immediately thereafter and revealed a fetal bradycardia, a decrease in the fetus' heart rate, in the range of 80 to 90 beats per minute. An acceptable fetal heart rate would have been one between 120 and 160 beats per minute. The situation was considered emergent because a protracted bradycardia is evidence that there is decreased blood flow and oxygen to the fetus, which could result in fetal injury or death. (Ex. 4, pp. 26, 52, 55, 59; T. 20, 22, 25-28)

6. Two physicians, Doctors Carinci and McManus, were located and came to the hospital to perform an emergency cesarean section. Anesthesia was administered beginning at 5:30 pm and Patient A's baby was delivered at approximately 5:46 pm. Surgery ended at approximately 6:35pm, with Respondent, according to his discharge summary, arriving on the floor sometime after 6:07, after the baby had been delivered, and while the uterus was being sutured. (Ex. 4, pp. 14, 26, 27, 35)

7. In 1998 in New York the accepted medical standard required that a fetus be delivered within thirty minutes of a recognized need for a cesarean section in an emergency and that a physician be available to render care to an obstetrical patient on a seven day a week, twenty-four hour a day basis. If the physician could not personally be available, the accepted medical standard required that responsibility for immediate patient care be assigned to someone else. (T. 32-35)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT A

The Committee **SUSTAINED** Factual Allegation A.1. The medical record demonstrated that Patient A's fetus was in distress and that an emergency delivery was necessary. The Committee rejected all contentions by Respondent that neither the patient nor her baby were at risk making an emergency delivery unnecessary. Respondent alleged that he had made an arrangement for coverage of his practice, before leaving for Connecticut, with Dr. McManus. Two nurses assigned to the labor and delivery room at that time each credibly testified that they were unaware of any such arrangement. As a result, the nursing staff had to locate an available obstetrician who could promptly travel to the hospital for the emergency delivery. Respondent arrived at the hospital more than one hour after the patient. Contrary to his position, the Committee considered that delay in Respondent's arrival and the failure to arrange in advance for replacement coverage and to notify appropriate hospital staff of such an arrangement to be a clear deviation from accepted standards of practice.

FINDINGS RELATED TO PATIENT B

8. Respondent initially saw Patient B, a fourteen year old female, on July 3, 2002. Respondent obtained a history from the patient, weighed and measured her, and performed a sonogram which indicated that the patient was at a gestational age of between twenty-eight and thirty-one weeks. No findings were documented for a pelvic examination or of assessments of Patient B's lungs, heart and breasts. Respondent did not conduct a physical examination of the patient on July 3, 2002. (Ex. 5, pp. 13, 22-23; T. 50, 53-54, 762)

9. Respondent collected and sent out a blood specimen for analysis on July 3, 2002. The results were reported on July 5, 2002 and indicated a mild anemia and a depressed platelet count of 46,000 with a reference range of 140,000 to 440,000. The risks posed to a fetus with a depressed platelet count include intra-cranial bleeding and stroke. There are also potential complications for the mother including intra-operative bleeding if a cesarean section is performed and problems with the administration of anesthesia. Respondent failed to assess the abnormal results, immediately repeat the test, or devise a plan of action to address them. (Ex. 5, p. 17; T. 54-58, 71-71)

10. Respondent next saw Patient B on July 16, 2002, at which time the patient's weight and blood pressure were obtained, an assessment was made of sugar and albumen in the patient's urine, and a sonogram was performed. No fetal heart rate was established, uterine fundal height and gestational age was not assessed or indicated. Respondent failed to address Patient B's low platelet count at this visit. (Ex. 5, p. 24; T 59-61, 762-763)

11. Patient B was again seen by Respondent on August 6, 2002, at which time weight and blood pressure were taken, a urine dipstick assessment was made, and fetal heart rate was recorded. No establishment of fetal gestation age was made and a corresponding measurement of uterine size was not performed. Fundal height should be measured and fetal heart rate assessed at such stage of pregnancy. Respondent also failed to address Patient B's low platelet count at this visit. (Ex. 5, p. 24; T 59-61, 762-763)

12. Patient B's final pre-natal visit with Respondent took place on August 20, 2002, at which time weight and blood pressure were obtained and it was noted that the patient's cervix was four centimeters dilated with bulging membranes. Fetal heart rate was not documenteded, nor was uterine size. The patient's urine was not tested; however, Patient B's blood was sent out for analysis and a genital culture was also performed. Screening for sexually transmitted diseases should have been performed on her initial visit and then repeated in the third trimester based on the patient's adolescent status and her pregnancy. (Ex. 5, pp. 14, 15, 19, 24; T. 59-64, 92-95)

13. Patient B was admitted to Long Island Jewish Medical Center early in the morning of the following day, August 21, 2002. Respondent's admission note indicated a rupture of membranes at 35-36 weeks. The patient's platelet count at 1:00 AM in the hospital was 29,000. She received a transfusion of single donor platelets prior to vaginal delivery by Respondent. Antibiotic prophylaxis should have been administered based on the absence of an available culture and Respondent's belief that the patient was delivering at 35-36 weeks gestation. Failure to treat a pre-term labor with appropriate antibiotics risks exposed the baby to infection and sepsis. (Ex. 6, pp. 13, 37-38, 47; T. 64-69, 71, 81-83)

14. Results of the August 20, 2002, genital culture were reported to Respondent on August 27, 2002. The culture yielded positive findings for both chlamydia and gonorrhea. Respondent next saw Patient B for a postpartum visit on September 3, 2002. Respondent's notes for that date reflected the positive chlamydia finding and a prescription for doxyclycline, an antibiotic. The medical record did not document that Respondent addressed the positive finding for gonorrhea or that he prescribed any course of treatment in response to such positive finding. Respondent's records also did not indicate that he referred the patient to a health center for treatment. Respondent again saw Patient B on October 1, 2002. There was no indication that Respondent retested the patient to determine that her two sexually transmitted diseases had resolved. (Ex. 5, pp.19, 24- 25; T. 73-75, 84-85, 798, 800)

15. Respondent deviated from accepted medical standards by failing to maintain an adequate medical record with sufficient information for pre-natal visits. (Ex. 5; T. 69-70, 95-96)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT B

The Committee **SUSTAINED** all Factual Allegations related to Respondent's treatment of Patient B. There was no evidence that demonstrated Respondent took any action to address the patient's low platelet count which continued from the initial encounter on July 3 through the delivery on August 21, 2002. The patient ultimately received a blood transfusion in the hospital when she was delivered. Contentions by Respondent that he had not accepted Patient B as his patient were considered unacceptable excuses for not appropriately addressing laboratory test results. Once those tests were performed, Respondent assumed a duty to respond to the results. Respondent also did not adequately respond to the positive findings of gonorrhea. He did not refer the patient for treatment elsewhere and did not follow-up when he again saw the patient subsequent to his receipt of the positive findings.

Patient B's baby was delivered pre-term and the Committee agreed with Dr. Wirth that accepted protocols required that an antibiotic prophylaxis be administered to address a potential for group beta strep infection. Respondent'd documentation of the pre-natal care he provided was clearly inadequate and failed to meet accepted standards of practice.

FINDINGS RELATED TO PATIENT C

16. Respondent began providing prenatal care to Patient C commencing on March 8, 2002 at which time the patient was at 9 weeks gestation. Respondent obtained a history from the patient, examined her and obtained a blood specimen. Laboratory results for the thyroid stimulating hormone (TSH) indicated a depressed level, outside of the normal range. The patient was retested on March 23, 2002 and the results again indicated a depressed TSH. Test results also indicated an elevated triiodothyronine total (T3). (Ex. 7, pp. 2, 3-4, 8, 12; T. 108-111, 130)

17. Respondent's medical record documented that he saw Patient C in his office on April 20, 2002. On that date he failed to record a fetal heart rate. Patient C was next seen on May 25, 2002, at which time it was noted that total placenta previa was present. Respondent did not record gestational age, maternal weight or blood pressure, urine dipstick results, or fetal heart rate. The patient saw Respondent on June 22, 2002, and there was again a failure by Respondent to note maternal weight and blood pressure, and urine dipstick results. Patient C saw Respondent on July 20, 2002 at which time a complete previa and maternal weight were noted, however maternal blood pressure, urine dipstick results, uterine size and fetal heart rate were not recorded. (Ex. 7, p. 2; Ex. 7A; T. 111-114,132)

18. Respondent next saw Patient C on July 31, 2002, at which time she reported that she "did not feel the baby all day yesterday." Respondent performed a sonogram and the finding "normal baby" was noted. Respondent's record did not indicate that either a fetal non-stress test or a biophysical profile were performed. The sonogram performed by Respondent on that date did not indicate an appropriate assessment of the fetus. (Ex. 7, p. 2; Ex 7A; T 114-119, 129-130, 145-146, 192-196, 202-203)

19. Respondent next saw Patient C on August 13, 2002. A fetal heart rate of 69 beats per minute was detected and the patient was sent to Long Island Jewish Hospital where she was admitted. Upon admission it was noted that there was minimal variability in the fetal heart rate and severe oligohydramnios, reflecting low amniotic fluid. A low level of amniotic fluid creates a greater potential for cord compression which could also jeopardize blood flow to the fetus. Respondent performed a cesarean section on Patient C on August 13, 2002. (Ex. 7, p. 2; Ex. 8, pp. 17, 22, 35, 37-38, 61-62; T. 119-125)

20. Respondent's record for Patient C did not contain the essential data which should have been ascertained at each of her prenatal visits and did not meet acceptable standards of medical practice. (Ex. 7; T. 132, 674-6)

<u>CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT C</u>

The Committee **<u>SUSTAINED</u>** Factual Allegations C.2. and C.3. and did **<u>NOT SUSTAIN</u>** Factual Allegation C.1.

Patient C's laboratory results from March, 2002 were not considered so abnormal as to be significant in light of her pregnancy. The Committee considered the abnormalities to be of limited significance and gave Respondent the benefit of the doubt in determining that his failure

to assess or follow-up those results was not a deviation from accepted standards of practice.

However, the Committee did conclude that the failures to record essential information about both the patient and fetus throughout the course of the pregnancy were deviations. The notation "normal baby" was an inadequate description based on Patient C's report of not feeling the baby. Respondent needed to better describe the findings from the sonogram he performed and the Committee members believed that a fetal non-stress test should have been performed. The record maintained by Responent for the patient was clearly inadequate.

FINDINGS RELATED TO PATIENT D

21. Patient D was admitted to South Nassau Communities Hospital on June 1, 1994, at 35-36 weeks gestation with a diagnosis of pre-eclampsia, a complication of pregnancy characterized by elevation of maternal blood pressure and the presence of protein in the urine. If allowed to worsen, the mother may have seizures and the placenta may deteriorate and separate from the uterus, compromising the growth of the fetus. The only manner to resolve the disease process of pre-eclampsia is to remove the placenta and bring the pregnancy to a conclusion. Therefore, a physician must weigh the need for the fetus to continue to grow and develop in the uterus against the dangers posed to mother and baby should the pregnancy be continued. (Ex 9 p 3, 20; T. 207-211, 217-218)

22. Respondent saw Patient D on June 2, 1994, and noted that this was a "typical case of pre-eclampsia." His plan was for the patient to undergo a sonogram, including an assessment of fetal weight, and an amniocentesis. If the L/S ratio was satisfactory, then the patient would be induced or a cesarean section would be performed. The L/S ratio is derived through an analysis of amniotic fluid and provides an assessment of fetal lung maturity, indicating the likelihood of respiratory distress following delivery.

23. Patient D had a sonogram on the following day which showed a 35 week fetus with an age-appropriate weight of 2490 grams. In the mid-1990's the prognosis of a baby at that gestational age and weight would have been comparable to that of a full-term baby. (Ex. 9, pp. 64- 65: T. 215-217, 219, 238-239)

24. Patient D's urine was being collected on a 24 hour basis and on June 4, 1994 there were 2.98 grams of protein in the 24 hour collection. This level of protein almost met the criteria for severe pre-eclampsia and indicated a degree of renal disease. On that day, Patient D complained of a slight headache, which also can be a sign of a worsening of the condition. Respondent's note of that day stated "Blood pressure is on way up again to 94 diastolic. It is obvious that her condition is not stable. Plan- do amniocentesis for L/S and deliver her if L/S favorable." (Ex. 9, p 66; T. 222-224)

25. An amniocentesis was performed on Patient D on June 6,1994. A nurse's entry in the progress notes dated June 6, 1994, reported the results of the amniocentesis as "LS Ratio 3.2, Pg positive." The reference range of the laboratory performing the analysis was that any ratio greater than 1.9 was indicative of fetal maturity. On the following page of the progress notes a Family Practice resident recorded the same L/S and PG results on June 7, 1994, with the note "discuss (or discussed) with Dr. Maric". Immediately below the resident's note, and on the same page, was one by Respondent on the same date which read in part: "L/S=3:2=1.5, not mature yet...In summary the lungs are NOT (sic) mature." Respondent's note did not refer to the positive PG. (Ex. 9, pp. 69, 70, 138; T. 225-226, 229, 261, 263-264, 612-613, 620-621)

26. On June 8, 1994, Respondent noted that Patient D's blood pressure was increasing. She was also experiencing increased reflexes, a sign of central nervous system irritability, and a possible prelude to stroke. Respondent's plan was to continue to observe the patient. No attempt

at induction was made, nor did the medical record reflect a discussion of the possible need for a cesarean section with the patient. (Ex. 9, p. 72; T 230-232, 247)

27. At 2:00 AM on June 9, 1994, the Family Practice resident was notified that Patient D's blood pressure had increased to 170/98, within the range for severe pre-eclampsia. The resident obtained a blood pressure which indicated the same result. The patient reported epigastric discomfort, a sign of the effects of pre-eclampsia on the liver. Patient D's condition continued to deteriorate that morning and Respondent's plan was to deliver the baby that day. The patient initially refused to consent to a cesarean section, but eventually gave her consent and the procedure was performed that morning by Respondent. (Ex. 9, p. 25, 73-76; T. 231-234)

28. Following the surgery Patient D had blood pressure as high as 180/112. She was severely thrombocytopenic, requiring her to receive platelet transfusions. The patient was transferred to the intensive care unit. (Ex. 9, pp. 118-119; T. 234-235)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT D

The Committee **SUSTAINED** all Factual Allegations related to Patient D. Factual Allegation D.2. was determined to constitute the practice of medicine with gross incompetence. Respondent's argument that he received the L/S ratio results via telephone and that there was a "miscommunication" as he believed he was not being given a ratio, but rather separate values, was rejected by the Committee. The usual and accepted manner of reporting those results by laboratories is in the form of a ratio, which Respondent would be expected to know. The entries in the medical chart by a nurse and a resident, each of which reflected a ratio of 3.2 were noted by the Committee. There was no excuse for Respondent to incorrectly determine the fetal lung maturity.

The Committee concluded Respondent was not justified in delaying the delivery of the fetus. There was no cause for Respondent to have permitted Patient D's condition to further deteriorate. The evidence that the patient initially refused a cesarian section delivery was inadequately documented in the medical chart and did not provide a basis for delay of the delivery. The Committee felt that the patient was inadequately counseled about her condition and the need for an immediate delivery of her baby.

FINDINGS RELATED TO PATIENT E

29. Patient E began receiving prenatal care at the South Nassau Family Practice Center of South Nassau Communities Hospital on June 3, 1991. Her estimated date of confinement as determined by ultrasound was December 21, 1991. A sonogram performed on October 29, 1991, at approximately 34-35 weeks gestation, revealed the fetus to be in a breech presentation. The record did not contain a report of a subsequent sonographic confirmation of breech presentation. (Ex. 10, p. 12-13; T. 162-163, 432-435)

30. Respondent saw Patient E for the first time on November 20, 1991. On December 12, 1991, Patient E presented to South Nassau Communities Hospital for an elective cesarean section. The Operative Report indicated that the patient was examined by a resident who verified the breech presentation. Respondent accepted the resident's conclusion, did not further examine the patient himself and proceeded to surgery on Patient E. Upon entry into the uterine cavity it was revealed that the fetus was in a vertex, not breech, presentation. (Ex. 10, p. 42; T 436, 442)

31. The standard of care in the New York metropolitan area at the time required, for an elective cesarean section, sonographic confirmation of breech presentation either a day prior to or on the day of surgery. (Ex. 10, p. 42; T. 166-168, 177, 436, 442)

32. Respondent deviated from accepted medical standards in failing to properly verify the breech presentation of Patient E's baby, thereby subjecting the patient to a surgery which was not medically indicated. (T. 169-170)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT E

The Committee **SUSTAINED** Factual Allegation E.1. Respondent admitted that he failed to properly verify the breech presentation. The Committee believed Respondent should not have relied on his earlier sonogram from October 29, 1991 because of the possibility that the fetus had reverted to a vertex presentation. Respondent should have personally verified the presentation instead of relying on the findings of the resident.

FINDINGS RELATED TO PATIENT F

33. Patient F began receiving prenatal care at the South Nassau Family Practice Center on April 24, 1992, at approximately 30-31 weeks gestation. Her estimated date of confinement upon which gestational age was estimated at the Family Practice Center was June 22, 1992.

34. Respondent saw the patient for the first time on July 7, 1992, at 42 weeks gestation. There had been an ultrasound of the patient on the previous day. A progress note by the Family Practice resident on July 7, 1992 indicated that, "as per Dr. Maric", Patient F was to be scheduled for a fetal non-stress test on July 15, 1992 and was to return to the Family Practice Center in one week. Polyhydramnios, an excess of amniotic fluid, was noted. (Ex. 11, pp. 30, 36; T. 286-291, 519)

35. A term pregnancy was considered any pregnancy between 37 and 42 weeks in 1992. The accepted standard permitted the continuation of a pregnancy one week beyond the commencement of the 42nd week, but required an assessment at the start of that week consisting of either a biophysical profile or a fetal non-stress test in order to ascertain the well-being of the fetus. Thereafter, at the commencement of the 43rd week the baby would be delivered. (T. 293-298, 304-305, 336-337)

36. Patient F presented at the Family Practice Center on July 14, 1992, complaining of absent or reduced fetal movement for 2 days. She was sent to Labor and Delivery where it was noted that the fetal heart rate lacked variability. Respondent examined the patient at approximately 12:42 PM and ordered a sonogram. Respondent's note of July 14, 1992, 12:30 PM reflected his findings of no fetal variability, and the need for a "stat"cesarean section due to fetal distress. Anesthesia was begun for Patient F at 1:30 and the surgery was commenced at 1:40. (Ex. 11, pp. 60, 65, 66, 69, 74, 80; T 298-301)

37. In 1992, accepted medical standards required that once a determination had been made that a cesarean section was needed due to fetal distress, the delivery should then be accomplished within 30 minutes to prevent possible injury to the fetus. The hospital record for Patient F did not reflect why the procedure was delayed, nor does it reflect what, if any, efforts were made by Respondent to effectuate a timely delivery. (Ex. 11; T. 302-305, 312-314)

38. Respondent deviated from accepted medical standards in that he did not appropriately manage her post-term pregnancy when, on July 7, 1992, he scheduled testing at too great an interval from her last bio-physical profile and beyond the point at which time she should have been delivered. (T. 295-297, 304-305)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT F

The Committee **SUSTAINED** Factual Allegation F.1. Factual Allegation F.2. was **NOT SUSTAINED**.

The Committee agreed with the opinion of Dr. Wirth that Respondent should have performed a follow-up assessment of Patient F sooner than July 15, 1992. The non-stress test he scheduled for July 15 would have taken place 9 days after her last bio-physical profile (the ultrasound of July 6) and would have occurred after the commencement of her 43rd week of pregnancy, at a time when the patient should have been delivered either by induction or cesarean section. The presence of polyhydramnios would have made it even more necessary that an assessment be made within a shorter time span.

The one hour period for performance of the emergency cesarean section surgery was noted to exceed the accepted practice standard. Respondent testified he attempted to conduct the surgery sooner, but a surgical suite was unavailable. While that fact should have been documented in the record, the Committee accepted Respondent's statement as reasonable and did not sustain Factual Allegation F.2.

FINDINGS RELATED TO DOCTOR H

39. In March, 1998, Doctor H was both director of Gynecologic Endoscopy in the Department of Obstetrics and Gynecology at South Nassau Communities Hospital and a member of the Quality Assurance Committee. Dr. H attended a peer review meeting in March, 1998 at which several of Respondent's cases were reviewed. Doctor H made comments which were critical of the care which Respondent had rendered and at the conclusion of the meeting Respondent approached Doctor H and said words to the effect of "If you keep doing what you are

doing to me, I'll fuck you." Doctor H asked Respondent to repeat what he had said and Respondent complied. (T. 478-482, 491, 744-749)

FINDINGS RELATED TO NURSES I AND J

40. On June 28, 2000, Respondent was to have performed a surgical procedure at South Nassau Communities Hospital. Respondent believed that a D&C hysteroscopy had been booked, while the case had been set up as a D&C only. Nurse J, a registered nurse who had been with the hospital for 19 years, brought the discrepancy to Respondent's attention. They sought to resolve the situation by speaking with Nurse I, the booking clerk at the time. Respondent was insistent that he had booked both procedures, with Nurse I in disagreement. During the course of this conversation, Respondent placed his thumb on one side of Nurse I's chin with his fingers on the other side of her face and shook her head back and forth, from side to side, repeating her name three times. (T. 349- 352, 372-375)

41. Following the incident with Nurse I, Nurse J sought to ascertain whether Respondent was credentialed to perform hysteroscopies. When she related to Respondent that she had been told by another physician that Respondent was not permitted to do them, Respondent again became insistent and demanded that Nurse J put what she had told him in writing. She refused and returned to the operating room desk. Respondent approached the desk and without asking Nurse J for her name, grabbed her identification badge which was hanging from around her neck at above waist level on a cloth lanyard. (T. 352-356, 364, 735)

FINDINGS RELATED TO DOCTOR H AND NURSES I AND J

The Committee sustained Factual Allegations G. and H. and concluded that the events substantially occurred as alleged. The testimony of Dr. H and Nurses I and J about these incidents was deemed credible and the Committee rejected arguments by Respondent that members of the hospital administration had somehow influenced their recollection of events.

It was determined that Respondent's actions, while clearly inappropriate and unprofessional, did not rise to the significance of constituting conduct that would evidence moral unfitness. As repugnant as his actions were, there was doubt as to what Respondent's intent was and how such actions were perceived by Doctor H and Nurses I and J. The Committee members believed the importance of these Allegations was outweighed by the preceding Allegations related to Respondent's medical care and treatment of patients. However, the Committee considered the events related to these two incidents in evaluating Respondent's ability to maintain working relationships with other medical personnel.

SPECIFICATION OF CHARGES

The Committee determined that all sustained Factual Allegations constituted the practice of medicine with negligence in that Respondent failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances of each case. These failures were not considered to be so egregious as to constitute the practice of medicine with gross negligence. Respondent was found to generally have the requisite skill and knowledge to practice and to not have practiced with incompetence, except for Factual Allegation D.2., as explained above. Failures to maintain a medical record for Patients B and C which accurately reflected the care and treatment of those patients were also found to constitute professional misconduct.

CREDIBILITY

The Committee closely reviewed the testimony of all witnesses to assess their credibility. The Department's case was exclusively based on the opinions offered by Dr. Wirth. The Committee believed

him to be well qualified in his experience. While at times his answers were evasive, he was considered to be objective in his testimony and very knowledgeable about obstetrical practice. He was not dogmatic and modified his answers when presented with new information. His testimony was accorded great weight by the Committee.

Respondent's testimony was argumentative and showed a lack of any insight as to errors on his part. He consistently refused to accept responsibility for his actions or inactions and attempted to shift blame to other physicians, nursing staff or even the patients themselves. He frequently offered unsupported conspiracy theories on the part of hospital staff and management in attempting to shift responsibility. His testimony was not objective and did not directly address the issues presented by the treatment he rendered. Respondent also demonstrated no understanding for the necessity to maintain acceptable standards of medical record keeping.

It was very apparent that Respondent has great difficulty accepting criticism and his inability to successfully work with other medical personnel became clear. Respondent often engaged in unwarrented, impolite and provocative questioning of witnesses during the course of this proceeding. His conduct placed on display personality defects that made it difficult for him to objectively discuss the charges of misconduct. Respondent continuously alleged that the hospital management and other medical personnel falsified testimony and medical records. No credible evidence was presented to support those charges and as a result, his testimony was found to not be believable and was rejected by the Committee.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee believed that there are minimal standards of record keeping that must be met by physicians and that adequate documentation is an essential part of medical care and treatment. Respondent's recordkeeping was too often non-existent leading to speculation as to what actually occurred in his care of the patients.

The Committee sustained multiple Specifications of Respondent's having practiced with negligence on more than one occasion and of failure to maintain adequate medical records and one Specification of having practiced with gross incompetence. Respondent testified that he maintains no current medical practice and has no hospital affiliations. The fact that he stated he has not practiced medicine since some time in 2003 in combination with the absence of any insight into his deficiencies and his inability to recognize his errors led the Committee to conclude that no amount of retraining or monitoring of his practice would be effective or adequately protect the public in the future and that revocation of his medical license would be the only appropriate penalty.

ORDER

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

1. The following Specification of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED**:

   First, Fifth (in part), Sixth and Seventh

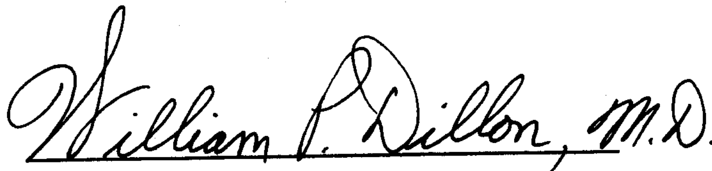
2. All other Specifications of professional misconduct are **NOT SUSTAINED** and are **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

4. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Troy, New York

10/26, **2005**



WILLIAM P. DILLON, M.D., CHAIRPERSON

RAVINDER MAMTANI, M.D.
CHARLES AHLERS

TO:

Leni S. Klaimitz, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007

Radoslav Maric, M.D.
P.O. Box 656
Ansonia, Connecticut 06401

Radislav Maric, M.D.
c/o Kreso Maric
Fraterscica 49
Zagreb, Croatia 10000

APPENDIX I

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

IN THE MATTER OF RADOSLAV MARIC , M.D.	STATEMENT OF CHARGES

Radoslav Maric, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 27, 1987, by the issuance of license number 169925 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided pre-natal care to Patient A. (The names of patients may be found in Appendix A, attached.) On or about November 26, 1998, Patient A presented at South Nassau Communities Hospital, located in Oceanside, New York, at 38 weeks gestation with bleeding. Fetal heart rates were in the 60 to 90 per minute range. Respondent was on staff at that hospital and had routinely admitted obstetrical patients to the hospital. Respondent was contacted by hospital staff when the patient presented, but was in Connecticut.

1. Respondent deviated from accepted medical standards in that he was unavailable to perform the required emergency cesarean section upon Patient A in a timely manner and had failed to make arrangements for appropriate cross-coverage with another physician.

B. Respondent initially saw Patient B, a 14 year old female at 29 weeks gestation, at his medical office located at 2045 North Milburn Avenue, Baldwin, New York, (hereinafter "medical office"), on or about July 3, 2002. Laboratory results for blood obtained on this visit indicated a platelet count of 46,000. Respondent

subsequently saw Patient B at his office on August 6 and August 20, 2002. A genital culture was obtained on the latter date, the results of which were unavailable when, on August 21, 2002, Patient B was admitted to Long Island Jewish Medical Center in New Hyde Park, New York, in pre-term labor. Upon admission the patient's platelet count was 29,000. Patient B received a platelet transfusion and delivered vaginally.

1. Respondent deviated from accepted medical standards in that he failed to appropriately address Patient B's abnormal platelet count of July 3, 2002,
2. Respondent deviated from accepted medical standards in that he failed to appropriately monitor Patient B's fetus during the course of pre-natal care. and failed to appropriately address positive findings of sexually transmitted disease
3. Respondent deviated from accepted medical standards in that he failed to administer antibiotic prophylaxis for pre-term labor to Patient B.
4. Respondent failed to maintain medical records which accurately reflect the care and treatment rendered to Patient B.

JA 6/21/05

C. Respondent began providing prenatal care to Patient C at his medical office commencing on or about March 8, 2002, when she presented at 9 weeks gestation. Laboratory results from blood samples obtained on that day indicated a depressed thyroid stimulating hormone (TSH) value. Follow-up studies from samples obtained on March 23, 2002, again indicated a depressed TSH level, as well as an elevated triiodothyronine level. Respondent saw Patient C on April 20, May 25, June 22, and July 20, 2002. Respondent's record reflects that on July 31, 2002, Patient C reported decreased fetal movement. Respondent documented fetal status in his record on that date with the notation "normal baby". Patient C was admitted to Long Island Jewish Medical Center on August 13, 2002, at 32 weeks gestation, with a non-reassuring fetal heart rate

and severe oligohydraminios. A cesarean section was performed by Respondent.

1. Respondent deviated from accepted medical standards in that he failed to appropriately address abnormal laboratory findings for Patient C.
2. Respondent deviated from accepted medical standards in that he failed to appropriately assess Patient C and her fetus during the course of prenatal care..
3. Respondent failed to maintain records which accurately reflect the care and treatment rendered to Patient C.

D. Patient D was admitted to South Nassau Communities Hospital in Oceanside, New York on June 1, 1994, with an elevated blood pressure at 35 weeks gestation. Respondent saw the patient the following day and noted that this was a "typical case of pre-eclampsia". Respondent indicated that the plan was for a sonogram, amniocentesis and "if L/S fine", induction or cesarean section. Respondent performed an amniocentesis on June 6, 1994, which revealed an L/S ratio of 3.2 and a positive phosphatidyl glycerl (PG). Respondent interpreted those results as indicating that "the lungs are not mature". Patient D's blood pressure worsened and a cesarean section was performed on her by Respondent on June 9, 1994. On or about June 10, 1994, Patient D was transferred to the Intensive Care Unit due to persistent severe pre-eclampsia.

1. Respondent deviated from accepted medical standards in that he failed to appropriately manage Patient D's pregnancy and delivery with respect to her pre-eclampsia.
2. Respondent deviated from accepted medical standards in his misinterpretation of fetal lung maturity.

E. Patient E presented to South Nassau Communities Hospital on December 11, 1991, for an elective cesarean section secondary to a presumed breech presentation. The medical record reflects that the breech presentation had last been confirmed by ultrasound on October 29, 1991. On admission a resident physician noted no dilation and a breech presentation of the fetus on examination. Respondent performed the cesarean section upon Patient E. At the time of the procedure it was discovered that the fetus was in a vertex presentation.

1. Respondent deviated from accepted medical standards in that he failed to personally verify the fetus' breech position by physical examination or ultrasound pre-operatively..

F. Patient F received prenatal care at the South Nassau Family Practice Center of South Nassau Communities Hospital. Her estimated delivery date was June 23, 1992. An ultrasound performed on July 6, 1992, at approximately 42 weeks gestation, noted a normal biophysical profile, other than polyhydramnios. Patient F was seen the following day for a check-up and "as per Dr. Maric" was scheduled for a non-stress test for July 15, 1992. Patient F presented to the Family Practice Center on July 14, 1992, reporting no fetal movement for two days. The patient was sent to labor and delivery where decreased or absent variability in the fetal heart rate was noted, she was examined by Respondent, and a cesarean section was performed by him.

1. Respondent deviated from accepted medical standards in that he failed to appropriately manage Patient F's post-term pregnancy.
2. Respondent deviated from accepted medical standards in that he failed to appropriately manage the care and delivery of Patient F following her admission to labor and delivery.

G In or about March 1998, at a meeting of the South Nassau Communities Hospital OB-GYN Performance Improvement Committee, Respondent behaved inappropriately and used profanity toward ~~Dr. G,~~ the hospital's director of OB-GYN. At the conclusion of the meeting Respondent approached Dr. H, another participant, and verbally threatened him.

H. On or about June ~~20~~ 28, 2000, during a dispute with operating room staff at South Nassau Communities Hospital, Respondent grabbed and moved Nurse I's chin back and forth. Respondent then grabbed the identification chain which was hanging from Nurse J's neck.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraph A and its subparagraph, Paragraph B and its subparagraphs, Paragraph C and its subparagraphs, Paragraph D and its subparagraphs, Paragraph E and its subparagraph, and Paragraph F and its subparagraphs.

SECOND AND THIRD SPECIFICATIONS

GROSS NEGLIGENCE

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

2. Paragraph A and its subparagraphs.
3. Paragraph D and its subparagraphs.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

4. Paragraph A and its subparagraph, Paragraph B and its subparagraphs, Paragraph C and its subparagraphs, Paragraph D and its subparagraphs, Paragraph E and its subparagraph, and Paragraph F and its subparagraphs.

FIFTH SPECIFICATION

GROSS INCOMPETENCE

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

5. Paragraph A and its subparagraph, Paragraph B and its subparagraphs, Paragraph C and its subparagraphs, Paragraph D and its subparagraphs, Paragraph E and its subparagraph, and Paragraph F and its subparagraph.

SIXTH AND SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in

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

6. Paragraph B and B(4).
7. Paragraph C and C(3).

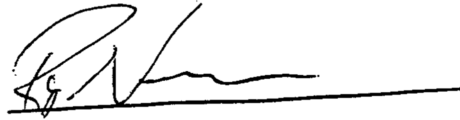
EIGHTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

8. Paragraph G and/or Paragraph H.

DATED: March 30, 2005
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct