STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

November 6, 1995

RECEIVED
NOV 07 1995
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Diane Abeloff, Esq.
NYS Dept. of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Alan Lambert, Esq.
Lipshutz, Polland & Associates
675 Third Avenue
New York, New York 14603

Sushila Gupta, M.D.
Redacted Address

RE: In the Matter of Sushila Gupta

Dear Ms. Abeloff, Mr. Lambert and Dr. Gupta :

Enclosed please find the corrected Determination and Order (No. 95-161) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This corrected copy is being sent to you due to an error in the first document sent to you on September 13, 1995. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER OF SUSHILA GUPTA, M.D.	ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 95-161

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1], held deliberations on October 13, 1995 to review the Hearing Committee on Professional Medical Conduct's July 31, 1995 Determination finding Dr. Sushila Gupta (Respondent) guilty of professional misconduct. The Respondent filed a Notice of Review, which the Review Board received on August 9, 1995. James F. Horan served as Administrative Officer to the Review Board. Dianne Abeloff, Esq. submitted a brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on September 21, 1995. Allan Lambert, Esq. submitted a brief for the Respondent, which the Board received on September 12, 1995, and submitted a reply brief, which the Review Board received on September 22, 1995.

SCOPE OF REVIEW

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

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

[1]Sumner Shapiro did not participate in the deliberations in this case.

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

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

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an obstetrician, with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and failing to maintain adequate records. The charges dealt with the Respondent's treatment of five obstetric patients, whom the record refers to as Patients A through E.

The Hearing Committee found that the Respondent was guilty of gross negligence in the treatment of Patients A through E, gross incompetence in the treatment of Patients A through E, negligence on more than one occasion, incompetence on more than occasion in the treatment of Patients A through E, and failing to maintain adequate records for Patients A through E.

The Hearing Committee found that the Respondent failed to perform and document an adequate medical history for Patients B, C and D. The Committee found that the Respondent failed to perform and document physical examinations for Patients C and D. The Committee found that the Respondent ordered and/or performed ultrasound exams that were not adequate or did not order sufficient ultrasound exams in the cases of Patients A, B, C and D. The Committee found that the Respondent failed to perform necessary lab tests for Patients A and B and failed to perform and document adequate prenatal care for Patients A and B. The Committee found that the Respondent failed to administer the drug RhoGAM to Patient A, who was rh negative. The Committee found that the Respondent incorrectly diagnosed an intrauterine pregnancy in the case of Patient C, when there was no medical indication for that diagnosis. The Committee found that the Respondent failed to appropriately treat Patient D, given the Patient's complaint of lack of fetal movement. The Committee also found that the Respondent was unavailable during delivery and did not provide coverage for delivery for Patient D. The Committee found that the Respondent abandoned Patient E while Patient

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E was in labor. The Committee noted that the Respondent ordered Patient E's membranes ruptured at 3:00 p.m. on the day of delivery, that the Patient went into second stage labor at 5:30 p.m. on that day, but that the Respondent did not arrive at the hospital for Patient E's delivery until 9:00 p.m. The Committee found in that case that the Respondent allowed Patient E to remain for an excessive amount of time in second stage labor, while the Patient's baby was in distress. The Committee also found that the Respondent inappropriately ordered the administration of oxytocin to Patient E.

The Committee found numerous instances in which the Respondent deviated from accepted medical standards. The Committee noted that the failure to perform the complete regimen of prenatal care and laboratory tests in the cases of Patients A and B demonstrated a lack of knowledge of the proper management of an obstetrical patient. In the treatment of Patient B, the Committee concluded that the Respondent failed to diagnose the presence of Spina Bifida in Patient B's infant. As to the incorrect diagnosis for intrauterine pregnancy in the case of Patient C, the Committee found that there were no definitive physical signs of an intrauterine pregnancy and that additional action on the Respondent's part was required. The Committee found that the failure to take such action jeopardized Patient C's life. In the case of Patient D, the Committee found that the Respondent failed to provide appropriate care to the Patient, because the Respondent did not follow up on the Patient's report that there was a lack of fetal movement. The Committee found that three days after reporting the lack of fetal movement to the Respondent, the Patient went into labor and delivered a still born baby girl. In the case of Patient E, the Committee found that the Respondent's absence from the hospital until 9:00 p.m. resulted in failure to properly evaluate the Patient. The Committee found that when a physician sends a patient into active labor at the hospital, that the physician has a duty to follow that patient.

In reaching their findings the Committee found the expert testimony by the Petitioner's expert Dr. David B. Peisner, was more credible than conflicting testimony by the Respondent, whose testimony the Committee found to be self serving. In reaching their conclusions concerning Patient D, the Committee found the testimony of Patient D to be more credible than the testimony of the Respondent's witness Mayra Acosta.

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The Committee found that the record in the case established that the Respondent does not possess the requisite professional skills or concern for her patients' well being to continue the practice of medicine. The Committee found that to allow the Respondent to continue practice would put her patients at risk. The Committee found that the Respondent demonstrated both gross negligence and gross incompetence in her practice of medicine on more than one occasion. The Committee voted unanimously to revoke the Respondent's license to practice medicine in New York State.

REQUESTS FOR REVIEW

RESPONDENT: The Respondent challenges the Committee's findings of fact and conclusions, alleges that the Committee's penalty is disproportionate to the findings of fact and conclusions and requests that the Review Board annul the Committee's Determination on the penalty.

The Respondent argues that the Committee denied her right to due process and a fair hearing, because the Committee failed to provide her with notice that her testimony would be disregarded by the Committee as self serving, in the absence of supporting testimony by an expert witness. The Respondent argues that the Committee failed to evaluate the overall credibility of the Respondent and the credibility, relevance and probative value of her testimony. The Respondent argues that, in finding the Petitioner's expert to be credible, the Committee did not make sufficient findings of fact on which to base their acceptance of the witness's testimony.

The Respondent argues that the Hearing Committee's Administrative Officer ruled improperly on excluding from evidence an affirmation which the Respondent offered. The affirmation dealt with the Respondent's arrangements for coverage for patients, at the time of Patient D's delivery. The Respondent argues that the Administrative Officer ruled improperly in admitting similar evidence offered by the Petitioner. The Respondent argues that these rulings and other rulings by the Administrative Officer demonstrated a pattern of incorrect and prejudicial evidentiary rulings throughout the hearing. The Respondent argues that these rulings demonstrate a pattern of bias by the Administrative Officer against the Respondent, that infected the entire hearing with unfairness.

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The Respondent argues that the Hearing Committee ignored inconsistencies in the testimony of Patient D, when the Committee made their finding that Patient D was a credible witness. The Respondent also argues that is was improper to allow a relative of Patient D to act as her Spanish language translator at the hearing. The Respondent argues that the Respondent had no assurance that the presence of Patient D's translator was not exerting an inappropriate or undue influence on Patient D's testimony. The Respondent argues that conflicting testimony by the Respondent's witness, Ms. Acosta, refuted Patient D 's testimony, and that there was no basis to find Patient D's testimony to be credible. The Respondent also argues that there was no evidence to support the determination by the Committee that the Respondent had ordered the oxytocin for Patient E.

The Respondent argues that even if the Review Board accepts the Committee's findings of fact, that the penalty of revocation is disproportionate to those findings and that the penalty should be annulled. The Respondent argues that if the Review Board determines that a penalty is warranted in the Respondent's case, that the proper penalty would be requiring the Respondent to pursue a course of additional education and residency training in the specialty of obstetrics and gynecology or, in the alternative, to limit the Respondent's practice to gynecology, until such time as she completes additional training in obstetrics and/or passes a board examination on obstetrics and gynecology. The Respondent notes that the findings concerning the Respondent's practice are restricted to the practice of obstetrics and do not challenge her ability to practice gynecology.

PETITIONER: The Petitioner contends that the Respondent's issues for review, with the exclusion of the issue concerning sanction, fall outside the Review Board's jurisdiction, and that even if the Review Board were to review the Respondent's other issues, the Review Board would find the Hearing Committee did not commit any due process violation. The Respondent argues that the Committee had the responsibility to determine the credibility for each witness and that the Committee acted appropriately when it decided to disregard the Respondent's testimony as self serving and when the Committee found Patient D's testimony to be more credible than that of Ms. Acosta.

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The Petitioner contends that the Respondent's comments, concerning the offered affirmation about coverage at the time of Patient D's delivery, were not appropriate before the Review Board and asks that the Review Board disregard page 8 of the Respondent's brief to the Review Board as well as the Exhibit A attached with the Respondent's brief. The Petitioner argues that the Respondent had an adequate opportunity to present evidence concerning coverage for Patient D's delivery through testimony at the hearing from Dr. Jean Turingan.

The Petitioner argues that revocation is the only appropriate sanction in this case. The Petitioner contends that the Committee found that the Respondent was negligent, grossly negligent and grossly incompetent in the care of the Patients involved in this case. The Petitioner argues that the variety and severity of the Respondent's misconduct indicate that the Respondent's deviations from proper standards of care were not isolated incidents, but occurred because the Respondent does not possess the requisite skill and concern for her patients to continue practicing medicine.

In response to the Petitioner's brief the Respondent contests the Petitioner's arguments concerning the limited scope of the Review Board's authority.

REVIEW BOARD DETERMINATION

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

Our statutory authority permits the Review Board to consider the record below and briefs which the parties have submitted. At the time that our Administrative Officer acknowledges receiving a Notice of Review, he advises the parties that their briefs may not contain evidence which was not before the Hearing Committee. For these reasons, the Review Board did not consider the affidavit which appears as Appendix A to the Respondent's brief, since that was not evidence which was before the Hearing Committee.

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The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion and failing to maintain adequate records for all Patients, A through E. The Committee's Determination on the specifications of misconduct is consistent with their findings of fact and conclusions that the Respondent failed to perform and document adequate medical histories, failed to perform and document physical examinations, ordered and performed ultrasound exams that were not adequate or were not sufficient, failed to perform necessary lab tests, failed to perform and document adequate prenatal care, failed to administer the drug RhoGAM to a patient who was rh negative, incorrectly diagnosed an intrauterine pregnancy, failed to appropriately treat a patient complaining of a lack of fetal movement, failed to provide adequate coverage for a patient's delivery, abandoned a patient, and ordered administration of oxytocin to a patient inappropriately. The Committee's Determination is consistent with those findings and with the Committee's conclusions that the Respondent deviated from acceptable medical standards, jeopardized a patient's life, demonstrated a lack of knowledge of proper management of obstetrical patients, failed to properly evaluate patients and abandoned a patient during the patient's second stage labor.

The Hearing Committee as finder of fact is the proper body to make a determination on the credibility of witnesses. In this case, the Committee found that the Department's expert Dr. Peisner was a credible witness and found that the Respondent was not a credible witness, due to her self-serving testimony. The Committee also found that Patient D was a more credible witness than the Respondent's witness Ms. Acosta. The Committee provided detailed explanations as to why they made their findings concerning credibility and the fact that they found one witness more credible than another does not constitute error. Since the Committee found the Respondent's testimony was not credible, there was then no credible expert testimony in the record that contradicted the Petitioner's expert Dr. Peisner. The Committee's statement on page 20 of their report, that the Respondent failed to present an independent expert to refute Dr. Peisner's testimony, was merely a statement of the obvious and did not constitute a denial of the Respondent's due process rights. Further as the Committee determined that the Respondent was not credible due to her self-serving testimony, it was not error for the Committee to reject the Respondent's testimony that she had not ordered oxytocin

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for Patient E, nor was it error for the Committee to base their finding that the Respondent had ordered oxytocin for Patient E upon a statement in the Patient's medical record (Petitioner's Exhibit 12).

The Review Board rejects the Respondent's contention that the Hearing Committee's Administrative Officer demonstrated bias against the Respondent. The record does not demonstrate any bias. The Respondent's contention that the Administrative Officer erred in excluding an affirmation by Dr. John Parente is a legal issue which is beyond the Review Board's authority. In the absence of Dr. Parente's affirmation at the hearing, the Respondent presented testimony from Dr. Jean Turingan concerning whether there was coverage for the delivery of Patient D. Neither Dr. Turingan's testimony nor Dr. Parente's affirmation addressed or contradicted the evidence that the Hearing Committee relied upon when reaching their finding that the Respondent did not provide coverage for Patient D's delivery. Hospital records from Patient D's delivery (Petitioner's Exhibit 11), indicated that the labor and delivery nurses called the Respondent's answering service and were referred to a doctor who informed them that he was not covering for the Respondent. The Respondent did not make the necessary arrangements for coverage of delivery, even if she had spoken to another physician about providing the coverage, if the Respondent did not provide that information to her patient, to the hospital at which the patient was to deliver or to the Respondent's own answering service.

The Review Board notes that even if we were to overturn the finding that the Respondent did not provide adequate coverage for Patient D's delivery, there is still adequate evidence in the record to find the Respondent guilty of gross negligence and gross incompetence in her care for Patient D. Further, even if the Review Board were to overturn the Committee's finding that the Respondent ordered administration of oxytocin to Patient E, there was still adequate evidence in the record to find the Respondent guilty of gross negligence and gross incompetence in the treatment of Patient E.

The Review Board votes 4-0 to sustain the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State. The Committee's penalty is appropriate given the serious nature of the Respondent's misconduct and it is consistent with the Committee's extensive findings regarding the Respondent's egregious and repeated acts of negligence and incompetence. The evidence in this case demonstrates that the Respondent does not possess the

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requisite professional skills or concern for her patient's well being to continue the practice of medicine. The Review Board agrees with the Committee that to allow the Respondent to continue practice would put her patients at risk.

The Review Board finds nothing in this record to indicate that the Respondent is a candidate for retraining. The evidence demonstrates that the Respondent lacks the ability, insight and motivation to be a successful candidate for retraining. The Board does not feel that we can protect the public health in this case by limiting the Respondent's license to prohibit her from practicing obstetrics and allow her to practice gynecology. The record demonstrates that the Respondent' deficiencies are so severe as to reflect that she lacks the requisite skills to practice medicine in general. The Respondent demonstrated an indifference to her patients safety and abandoned a patient at the most crucial stage of delivery. The Respondent also demonstrated that she lacked knowledge in the proper management of a patient, failed to make proper diagnoses, failed to perform or order adequate examinations, failed to perform necessary tests, failed to perform or document adequate prenatal care, failed to treat or address patients' complaints, and made inappropriate orders for medication. The egregious and repeated nature of the Respondent's misconduct demonstrates that the only appropriate penalty in this case is revocation of her license to practice in New York State.

The Review Board notes that even if we did overturn the Hearing Committee's finding that the Respondent did not provide adequate coverage for Patient D's delivery and even if we overrule the Hearing Committee's finding that the Respondent ordered oxytocin inappropriately for Patient E, there would still be more than sufficient evidence in this record to support the Hearing Committee's Determination to revoke the Respondent's license.

The Review Board votes to make one correction in the Hearing Committee's Report. On page 18 of the Report, the Committee states that they sustained the Fourteenth Specification of Misconduct against the Respondent based on factual allegations B2 and B4. The Committee, however, did not sustain allegation B2 (see Committee Report pages 15 and 23). The Review Board assumes that the Committee intended to sustain the Fourteenth Specification based upon factual allegations B1 and B4. The Review Board amends the Hearing Committee's Determination on page 18 to read that the Fourteenth Specification was sustained based on factual allegation B1 rather than B2.

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ORDER

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

1. The Review Board votes 4-0 to **SUSTAIN** the Hearing Committee on Professional Medical Conduct's July 31, 1995 Determination finding Dr. Sushila Gupta guilty of professional medical conduct.

2. The Review Board votes 4-0 to **SUSTAIN** the Hearing Committee's Determination to **REVOKE** the Respondent's license to practice medicine in New York State.

3. The Review Board corrects the Hearing Committee Determination as noted in page 9 of this Determination.

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

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IN THE MATTER OF SUSHILA GUPTA, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Gupta.

DATED: Albany, New York
Oct 27 **, 1995**

Redacted Signature

ROBERT M. BRIBER

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IN THE MATTER OF SUSHILA GUPTA, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Gupta.

DATED: Brooklyn, New York

10/25 **, 1995**

Redacted Signature

WINSTON S. PRICE, M.D.

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IN THE MATTER OF SUSHILA GUPTA, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Gupta.

DATED: Roslyn, New York
Oct. 27, 1995

Redacted Signature

EDWARD C. SINNOTT, M.D.

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IN THE MATTER OF SUSHILA GUPTA, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Gupta.

DATED: Syracuse, New York

30 Oct , **1995**

Redacted Signature

WILLIAM A. STEWART, M.D.

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