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

July 31, 1995

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MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Gopaljee Jaiswal, Esq.
55 West 39th Street
Suite 702
New York, New York 10018

Sushila Gupta, M.D.
Redacted Address

RE: In the Matter of Sushila Gupta, M.D.

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

Enclosed please find the Determination and Order (No. 95-161) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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 all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER OF SUSHILA GUPTA, M.D.	**DETERMINATION AND ORDER** BPMC-95-161

A Notice of Hearing and a Statement of Charges, dated December 7, 1994, were served upon the Respondent, Sushila Gupta, M.D. **ROBERT J. O'CONNOR, M.D. (Chair), DAVID HARRIS, M.D. and PRISCILLA LESLIE,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. The Respondent appeared by Gopaljee Jaiswal, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	December 10, 1994
Answer to Statement of Charges:	January 23, 1995
Pre-Hearing Conferences:	January 11 and 23, 1995

Dates of Hearing:	January 23, 1995 March 3, 1995 March 8, 1995 April 5, 1995
Witnesses for Department of Health:	Patient D David B. Peisner, M.D.
Witnesses for Respondent:	Sushila Gupta, M.D. Jean Turingan, M.D. Mayra Acosta Marion Kivlehan

STATEMENT OF CASE

The Respondent was charged with seventeen specifications of professional misconduct. The specifications include practicing with gross negligence, practicing with negligence on more than one occasion , practicing with gross incompetence, practicing with incompetence on more than one occasion and failing to maintain adequate records. The charges arise from the Respondent's treatment of five obstetrical patients from 1988 through 1994. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Hearing Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Hearing Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. SUSHILA GUPTA, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on July 15, 1977, by the issuance of license number 131542 by the New York State Education Department. (Petitioner's Exhibit 2[hereinafter "Pet.Ex."])

2. The Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1992, through December 30, 1994, with a registration address of 6 Theis Lane, Blauvelt, New York 10913. (Pet. Ex. 1)

GENERAL FINDINGS

3. An obstetrician's initial history of a patient should include a history of any diseases, infections, hospitalizations, previous pregnancies and any complications, family medical history, problems with medications and current medications being used. It should also contain a notation of any current complaint and whether there are any other medically significant problems. It should include a social history, a history of sexual activity and whether or not the patient smokes, drinks or uses drugs . (Transcript pp. 61-63,180 [hereinafter "T.61-63,180 " e.g.].)

4. A physician's initial physical examination for a confirmed pregnancy should include an examination of the head, eyes, ears, nose, throat, breasts, lungs, heart, abdomen, spine, the extremities, the pelvis, including the external genitalia and a determination of the bony shape of the pelvis to ascertain whether there may be any problems with delivering the baby. The physician should also examine the cervix. (T.65-66)

5. To be of value to the treating physician or any other physician who subsequently treats the patient, the medical record should note all the findings from the physical examination. Noting one's findings in the record is very important because a doctor sees many patients and unless the findings are recorded, it is very difficult to remember one's findings. Placing a check mark next to a system is not sufficiently descriptive. An individual who subsequently reviews the records will not always be able to determine if the check means normal or abnormal. Documentation is also important for the future management of the patient. (T.69-71,96,226)

6. In the medical practice of obstetrics, on occasion, a physician other than the treating physician, delivers the baby. (T.70)

8. Decreased fetal movement could be an indication that the fetus is having a problem which may require medical intervention. (T.73)

9. Measuring fundal height is an important benchmark of fetal development. If the fundus does not continue to increase, this failure to grow could be indicative of a problem which would need intervention. (T.73)

10. Every physician who performs ultrasound examinations is required to know what information should be obtained from that examination. (T.86)

11. The results of second and third trimester ultrasound examinations should show the presence of the fetus and if there are more than one; the amount of fluid surrounding the fetus; placenta localization; measurements of the fetus including biparietal diameter, femur length and in the third trimester head and abdominal circumference; the fetal anatomy including ventricles, a four chamber view of the heart, a view of the spine, stomach, bladder and kidneys; and a screening of the uterus and adnexa. (T. 81-82)

12. The correct way to measure biparietal diameter from an ultrasound picture is from the top edge to the top edge of the bones. Obtaining the correct measurements is important because the measurements are translated to tables which list gestational age of the fetus for that particular measurement. (T. 83)

PATIENT A

13. Patient A sought prenatal care from Respondent from on or about May 11, 1990 through November 1990. (Pet.Ex. 3)

14. The record for each prenatal visit should have included: fundal height in centimeters; fetal activity; fetal heart rate; weight; blood pressure, urine test for glucose and albumin, laboratory tests results. Respondent recorded some but not all the information at each visit. (T. 71-75, 105-107, 109,111,121- 123; Pet.Ex. 3; Respondent's Exhibit S [hereinafter Res.Ex. S, e.g.])

15. Respondent did not perform a glucose tolerance test, an alpha fetoprotein test (hereinafter "AFP"), pap smear, or VDRL, all necessary prenatal care tests. (T.

77-80; Pet. Ex. 3; Res. Ex. S)

16. Respondent's ultrasound examinations for this patient were missing the amount of fluid surrounding the fetus, placental localization, measurements of the fetus, which included the biparietal diameter, the femur length, measurements to assess growth, such as the head circumference and abdominal circumference of the fetus; a screen of the fetal anatomy which included the ventricles, the four chamber view of the heart, views of the spine, stomach, bladder, kidneys and extremities; and finally the Respondent failed to examine the uterus and the adnexa. The images were not correctly recorded when initially made in that the images were overexposed. (T. 81-85, 134; Pet.Ex. 3; Res.Ex. S)

17. Respondent attempted to measure the biparietal diameter; however, she measured it incorrectly. She measured the inner edges of the head. This measurement underestimated the size of the head and therefore underestimated the age of the fetus. (T. 83; Pet.Ex. 3; Res.Ex. S)

18. Patient A was RH negative, therefore, at approximately 28 weeks she should have received one shot of RhoGAM to prevent Rh disease. An obstetrician must note in the record the date that the RhoGAM was injected to insure an appropriate subsequent diagnosis if the patient develops antibodies for the RH positive factor. Respondent failed to administer RhoGAM to Patient A at the appropriate time. (T. 87-89; Pet.Ex. 3; Res. Ex. S)

19. On November 5, 1990, Patient A gave birth to a baby at Union Hospital of the Bronx. The Respondent did not deliver the baby. (Pet.Ex. 4)

PATIENT B

20. Responded treated Patient B from on or about September 23, 1988 through May 5, 1989. (T. 177; Pet. Ex.5; Res.Ex. T)

21. Patient B went to see Respondent on September 23, 1988, complaining of pain in her lower abdomen on one side. (T. 177; Pet.Ex. 5; Res.Ex. T)

22. Respondent's history for this patient consisted of the complaint and that the pain increases when urinating. (T. 179; Pet.Ex. 5; Res.Ex. T)

23. The Respondent did not inquire about possible pregnancy or ectopic pregnancy, about sexual history, recent or past infections, gastrointestinal problems, or trauma which could also cause pain nor did the Respondent note the nature of the pain on urination, location, whether it was sharp or dull, whether it was related to any particular time of day, all of which could help determine the source of the pain. (T. 177-180; Pet.Ex. 5; Res.Ex. T)

24. Since Respondent suspected an infection this patient should have had cultures of her urine, cervix and vagina. Additionally, a pregnancy test should have been performed to aid in the evaluation of a possible ectopic pregnancy. Respondent did not perform these laboratory tests for Patient B. (T. 183-184; Pet.Ex. 5; Res.Ex. T)

25. On September 30, 1988 Respondent became aware that the Patient was pregnant. (T. 184; Pet.Ex. 5; Res.Ex. T)

26. On or about October 10, 1989, the Respondent hospitalized the patient at the Bronx-Lebanon Hospital to rule out an ectopic pregnancy. (T. 186; Pet.Ex. 6)

27. Respondent did not perform an AFP test which is a necessary test for prenatal care. (T. 77-79,218; Pet. Ex. 5; Res. Ex. T)

28. The record for each prenatal visit should have included: fundal height in centimeters; fetal activity; fetal heart rate; weight; blood pressure, urine test for glucose and albumin, laboratory tests results. Respondent recorded some but not all

the information at each visit. Respondent failed to correctly note the fundal heights, the fetal heart rate was not always documented, the urine test results were not documented.(T. 185; Pet.Ex. 5, Res.Ex. T)

29. Respondent performed an ultrasound examination on Patient B on January 11, 1989, when the patient was approximately 19 weeks pregnant. (T. 194; Pet.Ex. 5; Res.Ex. T)

30. Respondent's ultrasound examination of January 11, 1989, for this patient was missing the amount of fluid surrounding the fetus, measurements of the fetus' femur length, the abdominal circumference of the fetus and the biparietal diameter was measured incorrectly in that it was measured from the inner edges of the head. This measurement underestimated the size of the head and therefore underestimated the age of the fetus. (T.192-193; Pet.Ex. 5; Res.Ex. T)

31. A time of gestation of approximately 19 weeks, is ideal for observing via a sonogram any abnormalities in the fetus because all of the organ systems in the fetus are well developed and the pregnancy has a large amount of fluid around the baby relative to the pregnancy, which makes it very easy to see the contours of the baby and to see any abnormalities, if present. This fetus suffered from spina bifida, an opening on the spine. The spine forms during the first few weeks of pregnancy and the spina bifida was present on this date.. Once the spine forms, it does not change anymore. At this time in the pregnancy, this condition can easily be imaged with the contrast of the surrounding fluid to determine if there are any out pouchings that would constitute a spina bifida. (T.194-196, 215- 216; Pet.Exs. 5,6; Res.Ex. T).

32. Respondent found no gross abnormality in the fetus based on the sonogram performed on January 11, 1989, although the fetus had a spina bifida on that date. (T. 192-196, 485; Pet.Exs. 5, 6; Res.Ex. T))

33. On or about March 23, 1989, a sonogram was performed on Patient B at

Bronx-Lebanon Hospital. The fetus was diagnosed with hydrocephalus and possible spina bifida. (Pet.Ex. 6)

34. On or about May 5, 1989 the patient changed obstetricians. (Pet.Ex. 5; Res.Ex. T)

35. In June of 1989 Patient B gave birth to a baby girl at North Central Bronx Hospital. The baby had spina bifida and hydrocephalus. (Pet.Ex. 7)

PATIENT C

36. Respondent treated Patient C in her office from on or about May 12, 1990 through May 16, 1990. (Pet.Ex. 8; Res.Ex. U)

37. Patient C went to see Respondent on May 12, 1990, complaining of pain in her lower abdomen. (T.256; Pet.Ex. 8: Res.Ex. U)

38. The medical history for this patient did not describe any past infections; recent history of sexual activity; gastrointestinal history, major illnesses, details of prior pregnancies or urinary complaints. Respondent documented the medication the patient was taking, nitroglycerin, but did not find out the history of the associated illness, the dosage or whether there were any current problems. (T. 257, 270-273, 277, 279,282- 284; Pet.Ex. 8; Res.Ex. U)

39. The Respondent performed a physical examination on this patient on May 12, 1990, but did not describe the cul-de-sac or the adnexa. A patient with either a suspected ectopic pregnancy or an infection, would have been tender in the adnexa and physical exploration may have revealed a mass, which would have assisted the Respondent in making an accurate diagnosis. (T. 258; Pet.Ex. 8; Res.Ex. U)

40. Respondent performed an ultrasound examination on May 15, 1990. The examination only showed the uterus; it did not show the adnexa or the cul-de-sac. Respondent determined that Patient C had an interuterine pregnancy. A sac in the

uterus is not a definitive indication of an interuterine pregnancy. To be conclusive of an intrauterine pregnancy an obstetrician needs to see fetal parts within the sac and if that is not seen, a definitive diagnosis of an intrauterine pregnancy cannot be made, and follow-up would be required. (T.259- 262,274; Pet.Ex. 8; Res. Exh.U)

41. There was no yolk sac or fetal parts visible in the ultrasound images made on May 15, 1990. (T. 262; Pet.Ex. 8; Res.Ex. U)

42. The patient had an ectopic pregnancy which ruptured and she was admitted to Metropolitan Hospital on May 25, 1990 and a linear salpingostomy was performed on May 26, 1990. (Pet.Ex. 9)

43. A proper interpretation of the ultrasound examination is imperative in a suspected ectopic pregnancy. Incorrectly diagnosing an ectopic pregnancy as an intrauterine pregnancy exposes the patient to danger because the fallopian tube could rupture and the patient could start bleeding internally. (T. 263)

PATIENT D

44. Respondent treated Patient D in her office from on or about September 28, 1993 through on or about June 4, 1994. (Pet.Ex. 10; Res.Ex. V)

45. Patient D went to Respondent on September 28, 1993 with complaints of discharge and frequency of urination. (T. 294; Pet.Ex. 10; Res.Ex. V)

46. The medical history for this patient did not contain an interval history of any medical diseases or family history, sexually transmissible diseases, urinary symptoms, any past infections or gastrointestinal problems. (T.314-316; Pet.Ex. 10; Res.Ex. V)

47. The Respondent performed a physical examination on this patient on September 28, 1993, but did not describe the cul-de-sac or the adnexa. The physical consisted of a review of the patient's physical systems and a check mark notation next to each system. (T. 296; Pet.Ex. 10: Res.Ex. V)

48. Respondent did not measure the fetal fundal heights appropriately and did not ascertain that the fetus was not growing normally. (T. 299-300,302; Pet.Ex. 10: Res.Ex. V)

49. On January 18, 1994, the Respondent performed an ultrasound examination on this patient. The examination did not include a measurement of the femur length, the abdominal circumference, the amount of amniotic fluid or a full description of the anatomy. The examination included a biparietal diameter using incorrect landmarks by placing the calipers in the wrong locations.(T. 298-299; Pet.Ex. 10; Res.Ex. V)

50. When a fetus is not growing normally ultrasound examinations should be done more regularly than usual to help determine the cause of the growth restriction. (T. 299,325)

51. Respondent performed ultrasound examinations on this patient on January 18, 1994 and May 9, 1994. (Res.Ex. V)

52. During the course of her office visit on June 1, 1994, Patient D told the Respondent that she did not feel the baby moving. Respondent did not document any fetal movement or lack thereof on that date, or on the earlier visit of May 25, 1994. Respondent did not order any diagnostic tests, such as a non-stress test or a biophysical profile, nor did she perform an ultrasound examination to help determine the well-being of the fetus. (T. 23-25,27-28,40,305; Pet.Ex. 10; Res.Ex. V)

53. Patient D went into labor on June 4, 1994 and went to Bronx-Lebanon

Hospital to deliver. Respondent was not present at anytime to assist in the delivery. The labor and delivery nurses called Respondent's answering service and were referred to a doctor who informed them that he was not covering for the Respondent. (T. 306-308)

54. If a physician is unavailable to attend a patient's delivery the physician must arrange for medical coverage and must communicate the coverage arrangement to the appropriate parties. (T. 307)

55. Respondent did not make the necessary arrangements for coverage of Patient D's delivery. (Pet.Ex. 11)

56. Patient delivered a stillborn girl on June 4, 1994. The baby was macerated. (T. 306,329; Pet.Ex. 11)

PATIENT E

57. Patient E went to see Respondent at her office on October, 20, 1992. Respondent told her she was in early labor and needed to go straight to the Bronx Lebanon Hospital, which she did. She was admitted to the hospital around noon. Upon admission she was placed on a fetal monitor. At or about 3:00 p.m., Dr. Randolph, a resident spoke by telephone with Respondent. Respondent told him to rupture Patient E's membranes. Respondent did not call to ascertain the condition of her patient after the membranes were ruptured. (T. 345,346,377, 620; Pet.Ex. 12)

58. Respondent was obligated to check on the status of her patient once she was admitted to the hospital in labor. She did not do this. (T.360)

59. Patient E was fully dilated at 5:30 p.m. Respondent was beeped at 6:00 p.m. Respondent was again contacted at 8:00 p.m., on October 20, 1994, at which time

she directed the Resident, Dr. Randolph, to begin oxytocin. (T. 346-347; Pet.Ex. 12)

60. Ordering oxytocin for Patient E at or about 8:00 p.m. was contraindicated when the fetus was at increased risk, which this fetus was. At or about 8:10 p.m. the fetal heart rate increased tremendously and there were deep decelerations, some of which have a long period of time to recover, and there had been the history of meconium staining. All of this information indicated that the baby was in trouble, that intervention, either delivery or evaluation was needed, not the administration of oxytocin. Oxytocin causes the uterus to contract more strongly; when the uterus contracts more strongly, it cuts off the blood supply to the fetus which is quite dangerous. (T. 355- 357, 370, 426; Pet.Ex. 12)

61. Patient E had been fully dilated and in the second stage of active labor since 5:30 p.m. Respondent was not in attendance at the hospital until 9:00 p.m. The Respondent was not at the hospital during the first three and one half hours of the patient's second stage of active labor. The baby could have delivered at any time during this time period . As the patient approached delivery, numerous situations could have developed which would have required the Respondent's intervention; e.g., fetal distress (as in this case), bleeding, or maternal problems. (T. 347-349,370; Pet.Ex. 12)

62. During the hours of 4:30 p.m. through 8:00 p.m. on October 20, 1992, Respondent was at her home. (T. 622-623)

63. This baby was not clinically compromised when labor began. There were no problems noted in the antepartum course, as described in the chart, and the heart rate on the tracings was initially quite strong. (T. 373, 659; Pet.Ex. 12)

64. The baby was delivered at or about 9:18 p.m., October 20, 1992. The baby had an Apgar score of zero at one minute after birth and a score of two at five minutes after birth. (T. 372-373; Pet.Ex. 12)

65. Patient E was in the second stage of labor for 3 hours and 48 minutes. In this case that was an excessive amount of time because the baby was in distress. The distress was signaled first by the meconium staining, which occurred when the membranes were first ruptured at around 3:00 p.m. and then when the fetal heart monitoring showed numerous changes. The fetal heart tracings showed an increase in the fetal heart rate and an increase in the amount, as well as the depth and length of the heart decelerations. The longer length of time to return to the baseline is an indication that the fetus is having more trouble recovering. This information indicated that intervention was required by either immediate delivery or evaluation. Respondent did neither. (T. 350-354, 369-370; Pet.Ex. 12)

66. There was no note in the record from Respondent, except for her signature on the delivery note. Respondent did not evaluate the fetal monitoring tracing when she arrived at the hospital. (T. 355; Pet.Ex. 12)

67. Respondent did not document anything about this patient's labor. The fetal monitoring tracings stopped at 8:50 p.m., however, the baby was not actually delivered until 9:18 p.m., yet the fetal heart rate was not monitored from 8:50 p.m. until delivery. In addition, on the labor-delivery puerperium summary Respondent inaccurately described the condition of the fetus during labor. Respondent wrote that the fetus was in good condition during labor, when the fetus was in distress for several hours. (T. 358-360, 371; Pet.Ex. 12)

Conclusions

The following conclusions were made pursuant to the Findings of Fact listed above. The Hearing Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A: (13,19);

Paragraph A.3: (14);

Paragraph A.4: (10,11,12,16,17);

Paragraph A.5: (15);

Paragraph A.6: (18);

Paragraph B: (20,26,32,33,34,35)(the Hearing Committee takes official notice that Paragraph B contains a typographical error in that the Patient was hospitalized at the Bronx-Lebanon Hospital on October 10, *1988* not October 10, 1989);

Paragraph B.1: (3,22,23);

Paragraph B.3: (5,24,27);

Paragraph B.4: (4,5,27,28);

Paragraph B.5: (10,11,12,30,31);

Paragraph C: (36,40,42);

Paragraph C.1: (3,38)

Paragraph C.2: (4,5,39)

Paragraph C.3: (40,42);

Paragraph C.4: (10,40);

Paragraph D: (44,53,56);

Paragraph D.1: (3,46);

Paragraph D.2: (4,5,47);

Paragraph D.3: (50,51);

Paragraph D.5: (10,11,49,51);

Paragraph D.6: (8,52);

Paragraph D.7: (53-55);

Paragraph E: with the exception of the first sentence of Paragraph E. (57,59,61,64,65);

Paragraph E.1: (59,60);

Paragraph E.2: (61,65);

Paragraph E.3: (65);

Paragraph E.4: (61,65);

Paragraph E.5: (66,67)

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

First Specification: (Paragraphs A., and A.3-6.);

Second Specification: (Paragraphs B., B.1 and B.3-5);

Third Specification: (Paragraphs C. and C.1-4);

Fourth Specification: (Paragraphs D., D.1-3 and D.5-7);

Fifth Specification: (Paragraphs E., and E.1-5);

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Sixth Specification: (Paragraphs A.,A.3-6,B.,B.1. B.3-5, C.,C.1-4, D.,D.1-3, D.5-7, E.,E.1-5);

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Seventh Specification: (Paragraphs A. and A.3-6);

Eighth Specification: (Paragraphs B., B.1 and B.3-5)(with the official notice noted above regarding Paragraph B.);

Ninth Specification: (Paragraphs C. and C.1-4);

Tenth Specification: (Paragraphs D., D.1-3, and D.5-7);

Eleventh Specification: (Paragraphs E. and E.1-5)(with the exception noted above)

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Twelfth Specification: (Paragraphs A.,A.3-6,B.,B.1,B.3-5,C.,C.1-4,D.,D.1-3,D.5-7,E.,E.1-5);

FAILURE TO MAINTAIN ACCURATE RECORDS

Thirteenth Specification: (Paragraph A.3);

Fourteenth Specification: (Paragraphs B.2 and B.4);

Fifteenth Specification: (Paragraphs C.1 and C.2);

Sixteenth Specification: (Paragraphs D.1,D.2 and D.6);

Seventeenth Specification: (Paragraph E.5)

DISCUSSION

Respondent was charged with seventeen specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., 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 gross negligence, negligence, gross incompetence and incompetence in the practice of medicine.

The following definitions were utilized 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.

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the seventeen specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented David B. Peisner, M.D. as its expert witness. Dr. Peisner is a physician whose specialty is obstetrics and gynecology. In addition, he is board certified in obstetrics and gynecology and the subspecialty of maternal neonatal medicine which deals with high risk pregnancies. There was no evidence of any bias on the part of Dr. Peisner or his unsuitability as an expert witness. The Hearing Committee found him to be a credible witness. Dr. Peisner repeatedly testified that the Respondent's patient histories, physical examinations, laboratory work-ups, pre-natal care and ultrasound examinations for the patients presented did not meet acceptable standards of medical care. With the few exceptions noted, the Hearing Committee found his testimony to be convincing and accurate. The Respondent did not present an independent expert witness to refute any of Dr. Peisner's testimony but presented her own opinion testimony as to the appropriateness of her professional conduct. This was disregarded for the most part as self-serving statements.

Patient A

The Petitioner's expert concluded that the Respondent's history and physical examination for this patient deviated from acceptable medical standards. The Hearing Committee disagreed with that opinion based on the documentation contained in Pet.Ex. 3 and Res.Ex. S. They found that although the care provided was not exemplary, it did not fall below acceptable medical standards and therefore determined that Factual Allegations, Paragraphs A.1 and A.2 were not proven by a preponderance of evidence.

The Hearing Committee found the Respondent's pre-natal care for this patient to be substandard. The information needed to be contained in each visit was not there. The Respondent failed to document fetal activity or lack thereof for each pre-natal visit. Such information is important because it could be indicative of fetal problems. Also, the Respondent inaccurately measured the fundal height. Accurately measuring the fundal height is a key to detecting problems with a fetus that is not developing normally. Additionally, the Respondent did not record the fetal heart rate at each visit. These omissions amounted to care which did not meet accepted medical standards.

The Respondent performed two ultrasound examinations on this patient. Both were found to be deficient. Any physician who undertakes to perform such examinations must have the requisite skills to perform and interpret them. Based on the evidence presented, the Hearing Committee found that the Respondent did not perform and interpret these tests competently. The tests and the accompanying report lacked an image and/or a description of the amniotic fluid, fetal movement, accurate biparietal measurements, the uterus, the adnexa and the

fetal anatomy. Additionally the images were overexposed. If a physician cannot perform such tests competently she should refer her patient elsewhere. The Respondent did not, thus putting her patient at risk.

As part of a complete regimen of pre-natal care there are a number of laboratory tests which must be performed. The Hearing Committee found that the Respondent did not perform or order all of the necessary pre-natal tests. This failure on the part of the Respondent represents a lack of knowledge of the proper management of an obstetrical patient. Of particular significance was the failure to administer an alpha-fetoprotein test which may alert a physician to possible neuro-tubal abnormalities in the fetus.

This patient's blood type was O-Rh negative. Because of her negative blood type she needed to receive a shot of RhoGAM at approximate the 28th week of pregnancy. Although the Respondent testified that she did so there was no record of her administering this medication and the Committee determined that she had not done so. The Committee found it incredible that 4 and one half years after allegedly administering an injection she recalled the act. This failure was a breach of the minimum standard of care.

Patient B

This patient went to the Respondent for treatment on September 23, 1988. The patient came to see the Respondent complaining of pain in the lower abdomen. The prior history notes were approximately three years old. No interim history was elicited. The respondent failed to inquire about recent past

infections, injuries or any recent trauma nor was the presenting symptom fully explored. The history contained in Res.Ex. T did not meet acceptable standards of care. However the documentation in that exhibit did establish to the Committee's satisfaction that she had performed an adequate physical on this patient, therefore the Committee concluded that Factual Allegation, Paragraph B.2 was not proven by a preponderance of evidence.

The Respondent had a duty to order/perform various laboratory tests in treating this patient. She should have performed a pregnancy test on the visit of September 23, 1988. Also, she should also have cultured this patient's urine, cervix and vagina in an attempt to determine if an infection was present. She did not do any of this. Nor did the Respondent, in the course of the pregnancy, perform an AFP test on this patient. Furthermore, the Respondent's record does not contain documentation of those laboratory tests that were performed. The Respondent's failure to record these results falls below acceptable standards of medical care.

Additionally the Hearing Committee agreed with the Department's expert witness that the pre-natal care provided was not acceptable. The fundal heights were inaccurately measured, and the fetal heart rate and fetal activity were not documented for all visits.

The Respondent's ultra sound examination of this patient was deficient in that it did not describe the amount of amniotic fluid, the length of the femur or the abdominal circumference. Nor did the Respondent measure the biparietal diameter correctly. Most important, the Respondent failed to diagnose the presence of a spina bifida. The ultrasound test was performed at approximately

19 weeks gestation. Had the Respondent possessed the necessary skill and knowledge to perform a medically competent ultra sound examination the spina bifida would have been detected. Instead the Respondent reported "no gross abnormalities" in her test report. It is essential for an obstetrician to properly interpret an ultrasound examination, particularly at this stage of the pregnancy. Accurate information presents patients with various options and if proceeding with the pregnancy is the path chosen then the information is invaluable for the obstetrical management of the pregnancy and delivery.

The Hearing Committee concluded that the evidence did not prove that Respondent's hospitalization of this patient for a possible ectopic pregnancy was not medically unnecessary. The Department's expert witness testified that admission for a possible ectopic pregnancy is the "standard of care." Therefore, Factual Allegation, B.6 was not proven.

Patient C

The Hearing Committee found Respondent's medical history of this patient was inadequate. There was no information of past or recent infection. There was no information on the patient's sexual practices nor any indepth description of urinary complaints which may have been the cause of the patient's lower abdominal pain. Of particular significance is the notation that the patient was taking nitroglycerin, yet the Respondent made no inquiry about why the patient is taking this medication.

This patient had a complaint of pain in the abdomen. However, the Respondent's physical did not include an examination of the cul-de-sac or a

description of the adnexa and whether there was any pain or masses present there. Given the patient's complaint, this should have been done. This information was particularly important for this patient. A patient with either a suspected ectopic pregnancy or an infection, would have been tender in the adnexa. If Respondent had palpated the adnexa, she may have felt a mass. This information may have assisted the Respondent in making an accurate diagnosis.

The Hearing Committee also found that the Respondent incorrectly diagnosed an intrauterine pregnancy in this patient when there was no medical basis, given the ultrasound images, to make such a diagnosis. The Hearing Committee agreed with the expert, that a definitive diagnosis of intrauterine pregnancy could not have been made from the May 15, 1990 ultrasound. There were no definitive visible signs of an intrauterine pregnancy, and additional action on the part of the Respondent was required. This failure to take such action jeopardized this patient's life. The patient's ultrasound examination did not meet accepted medical standards because it did not contain an image of the adnexa or the cul-de-sac and the area around the uterus. As a result of the substandard ultrasound examination, Respondent arrived at an incorrect diagnosis of the patient's condition.

Patient D

The Respondent failed to obtain an adequate medical history of this patient. The patient came to see the Respondent on September 28, 1993. The

last history was obtained in 1988. Yet, the Respondent did not include an interval history of any diseases, hospitalizations, operations, infections, or note a lack of these for the September 1993 visit. Nor is there a family history covering this interval visit. The Respondent's physical examination of this patient consisted of check marks next to various parts of the body, which indicate the part of the body was examined, but do not indicate what was found upon examination. Additionally, the physical had no description of the adnexa or the cul-de-sac.

In this case, the fetus was growth restricted. However, the Respondent failed to diagnose this due to her inaccurately measuring the fundal height. As a result she failed to perform an adequate number of ultrasound examinations on this patient. These additional tests are the standard of care when a physician is presented with a fetus that is not growing normally. The Respondent did not ascertain this, which, in turn lead to her failure to perform an adequate number of ultrasound examinations. Additionally, the ultrasound test she performed on January 18, 1994, did not meet acceptable medical standards because it did not include a measurement of the femur length, an accurate measurement of the biaparietal diameter, the abdominal circumference, the amount of amniotic fluid, nor a full description of the anatomy.

Patient D testified that she informed the Respondent on June 1, 1994, that she did not feel the baby moving. The Hearing Committee found this witness to be credible. The Respondent's witness, Mayra Acosta, a certified nurse assistant, who works for the Respondent, testified that Patient D did not inform the Respondent on June 1, 1994 about the lack of fetal movement. Patient D's memory of her own conversations of her pregnancy with Respondent were more

credible than the memory of Respondent's nurse. There was nothing so unusual about the June 1, 1994 visit that would cause Ms. Acosta to remember that visit compared to the concern and anxiety experienced by the patient which would cause the patient to remember what she told Respondent. Ms. Acosta testified that the Respondent sees approximately 140 patients a week, that she works approximately 50 weeks a year, and she has worked for the Respondent for three (3) years. The Hearing Committee found her testimony, regarding what Patient D told the Respondent on June 1, 1994, not credible.

Since the Hearing Committee concluded that the Respondent was informed of the lack of fetal movement on June 1, 1994, it was also determined that her inaction amounted to a failure to provide appropriate care to this patient. She should have ordered diagnostic tests to assess the status of the fetus. Her failure to do this amounted to a failure to provide appropriate care to Patient D.

This patient went into labor on June 4, 1994, and delivered a stillborn baby girl. The Respondent was not available to deliver the baby. The Respondent knew she was going away, however, she failed to provide coverage for this patient. It was her responsibility to insure that all parties involved were aware of exactly who was covering for her. The record indicates she did not do this and medical coverage of this patient's delivery was by default. The Respondent's conduct represents a departure from accepted medical standards.

The Hearing Committee concluded that the evidence did not support the allegation of a failure to treat the patient appropriately given the history of sickle cell anemia. The Respondent took the necessary steps to manage this aspect of the patient's care by referring her for genetic counseling. This was sufficient

given that the patient did not present any complaint of urinary tract infection. therefore, the Factual Allegation, Paragraph D.4 was not proven by a preponderance of evidence.

Patient E

The Hearing Committee concluded that the Respondent's care of this patient amounted to abandoning the patient. The documentation in the record is clear and unrefuted. When a physician sends a patient in active labor to the hospital she has a duty to follow that patient. Instead the Respondent went home. The patient was admitted to the hospital shortly after noon. The Respondent's provision of care for this patient consisted of ordering the rupture of the patient's membrane via the telephone at approximately 3:00 p.m. and ordering Oxytocin at approximately 8:00 p.m. The patient went into second stage labor at approximately 5:30 p.m. Respondent did not appear at the hospital until approximately 9:00 p.m. Respondent never called to inquire as to the findings after the ruptured membranes. She testified she tried to contact the hospital at approximately 6:30 p.m., at least 3 1/2 hours after the patient was admitted, but the line was busy. At that time she did not proceed to the hospital to check on the condition of her patient but remained at home. By approximately 7:00 p.m. the resident was finally able to reach Respondent, over four hours after the patient was admitted to the hospital. Respondent still did not arrive at the hospital for another two hours. Two hours in which the fetus was in distress, as demonstrated by the fetal heart monitor tracings.

The Respondent testified that she did not order the Oxytocin. However, the hospital record is quite clear and the Hearing Committee concurred, that it was given per her order. She did not produce a witness who may have bolstered the credibility of her testimony. In support of her denial the Respondent introduced into evidence what was purported to be a copy of part of a hospital manual which related to the ordering of Oxytocin. It was unsigned, not certified as to authenticity and inconsistent with respect to which category of physician can authorize the administration of this drug. The Hearing Committee therefore gave it no weight. The ordering of Oxytocin was medically contraindicated at that time. The fetus was having problems which could be exacerbated by giving this patient Oxytocin.

The Respondent's absence from the hospital until 9:00 p.m. resulted in her failure to properly evaluate her patient. Had she been there she would have noted the fetal monitoring tracing indicated that the fetus was in distress and required intervention prior to 9:00 p.m. Yet the Respondent did not do any evaluation of the condition of the fetus throughout the labor since she was not present. Nor did she document a review of the fetal monitoring tracings subsequent to her arrival. After delivery she simply signed the "Labor-Delivery-Puerperium Summary" and indicated that the condition of the fetus during labor was "good." The hospital record for Patient E was not maintained in accordance with accepted medical standards. It was the Respondent's responsibility to ensure that the record met accepted standards.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth 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 record in this case clearly established that Respondent does not possess the requisite professional skills or concern for her patients well being to continue the practice of medicine. To allow her to continue to practice would put her patients at risk. Respondent has demonstrated both gross negligence and gross incompetence in her practice of medicine on more than one occasion.

The Hearing Committee unanimously determined that no sanction short of revocation would adequately protect the public.

ORDER

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

1. The First through Seventeenth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

2. Respondent's license to practice medicine in New York State be and hereby is **REVOKED.**

DATED: New York, New York
7/25 , 1995

Redacted Signature

ROBERT J. O'CONNOR, M.D. (CHAIR)

DAVID HARRIS, M.D.
PRISCILLA LESLIE

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Sushila Gupta, M.D.
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APPENDIX I

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

IN THE MATTER	: STATEMENT
OF	: OF
SUSHILA GUPTA, M.D.	: CHARGES

SUSHILA GUPTA, M.D., the Respondent, was authorized to practice medicine in New York State on July 15, 1977 by the issuance of license number 131542 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1992 through December 31, 1994 from 6 Theis Lane, Blauvelt, New York, 10913.

FACTUAL ALLEGATIONS

Patient A

A. From on or about May 11, 1990, through November 1990, Respondent treated Patient A at her office, 1575 Grand Concourse, Bronx, N.Y. (The identity of Patient A and the other patients is contained in the attached appendix.) On or about November 5, 1990, Patient A delivered a baby at Union Hospital, Bronx, N.Y. Respondent did not deliver the baby.

1. Respondent failed to perform and document an adequate history for Patient A.

2. Respondent failed to perform and note an adequate physical examination of Patient A on or about May 11, 1990.

3. Respondent failed to perform and document necessary pre-natal care of Patient A.

4. The ultrasound examinations Respondent performed on Patient A and interpreted on or about May 11 and October 5, 1990 were not adequate.

5. During the course of Patient A's pre-natal care, Respondent failed to perform and/or order necessary laboratory tests for Patient A.

6. During the course of Patient A's pre-natal care, Respondent failed to administer RhoGAM to Patient A, a woman with an RH negative blood type.

PATIENT B

B. From on or about September 23, 1988, to on or about May 5, 1989, Respondent treated Patient B at her office. On or

about October 10, 1989, Respondent hospitalized Patient B at Bronx-Lebanon Hospital, Bronx, N.Y., to rule out an ectopic pregnancy. On or about January 11, 1989, Respondent performed an ultrasound examination on Patient B. Respondent interpreted this ultrasound examination as showing no abnormalities. On or about March 23, 1989, at Bronx Lebanon Hospital, Patient B's baby was diagnosed with hydrocephalus and possibly spina bifida. On or about May 5, 1989, Patient B switched obstetricians. In or about June 1989, Patient B gave birth at North Central Bronx Hospital, Bronx, N.Y. to a baby with spina bifida and hydrocephalus.

1. Respondent failed to perform and document an adequate history of Patient B.

2. Respondent failed to perform and document an adequate physical examination of Patient B on or about September 23, 1988.

3. During the course of Patient B's pre-natal care, Respondent failed to perform and/or order necessary laboratory tests.

4. Respondent failed to perform and document necessary pre-natal care of Patient B.

5. The sonogram Respondent performed on Patient B and interpreted by Respondent was not adequate.

6. Respondent's hospitalization of Patient B at Bronx Lebanon Hospital on or about October 10, 1988 was not medically necessary.

Patient C

C. From on or about May 12, 1990 to on or about May 16, 1990, Respondent treated Patient C at her office. On or about May 16, 1990, Respondent diagnosed Patient C as having an intrauterine pregnancy. On or about May 25, 1990, Patient C was admitted to Metropolitan Hospital, N.Y., N.Y. for a right ectopic pregnancy. A linear salpingectomy was performed at Metropolitan Hospital on or about May 26, 1990.

1. Respondent failed to perform and document an adequate history of Patient C.

2. Respondent failed to perform and document an adequate physical examination of Patient C.

3. On or about May 16, 1990, Respondent incorrectly diagnosed an intrauterine pregnancy when Patient C actually had an ectopic pregnancy.

4. The ultrasound examination Respondent performed and/or interpreted on or about May 16, 1990 was not adequate.

Patient D

D. From on or about September 28, 1993 to on or about June 4, 1994, Respondent treated Patient D at her office. On or about June 4, 1994, at Bronx Lebanon Hospital, Patient D delivered a macerated stillborn girl. Respondent was not present at the delivery.

1. Respondent failed to perform and document an adequate history of Patient D.

2. Respondent failed to perform and document adequate physical examinations of Patient D on or about September 28, 1993.

3. Respondent failed to provide Patient D with sufficient ~~pre-natal visits~~.
ultrasound examinations
JWK 7/19/95

4. Respondent failed to treat Patient D appropriately given the patient's history of sickle cell anemia trait.

5. The ultrasound examination that Respondent performed and interpreted on or about January 18, 1994, was not adequate.

6. On or about June 1, 1994, Patient D complained to Respondent that she did not feel fetal movement. Respondent failed to treat the Patient D appropriately given her complaint of lack of fetal movement.

7. At the time that Patient D went into labor and throughout the duration of the delivery Respondent was unavailable and did not provide any coverage of her medical practice.

Patient E

E. From on or about April 4, 1992, through on or about October 20, 1992, Respondent treated Patient E at her office. On or about October 20, 1992, Patient E went to Bronx Lebanon Hospital in labor. At or about noon on October 20, 1992, Patient E was admitted to the hospital. Respondent was

notified but she did not go to the hospital. By at or about 3:00 p.m., another physician ruptured Patient E's membranes; there was light meconium staining. Labor progressed normally and the patient was fully dilated at 5:30 p.m. Respondent was notified, but did not come to the hospital. She was contacted again at 7:00 p.m., but did not come to the hospital until after 9:00 p.m. From at or about 6:40 p.m. until delivery at 9:18 p.m., the fetal heart rate indicated that the fetus was in distress. At delivery, the infant was depressed and had APGAR scores of 0 at one minute and 2 at five minutes.

1. Respondent inappropriately ordered Pitocin at or about 8:00 p.m.

2. Respondent's absence from the hospital when Patient E was in active labor, particularly the second stage, prevented her from appropriately evaluating Patient E's condition.

3. Respondent allowed the patient to remain in the second stage of labor for too long without appropriate intervention.

4. Respondent failed to properly evaluate the fetal heart rate tracings;she thereby, allowed Patient E's fetus to

be in distress for more than two hours without intervention.

5. Respondent failed to adequately document in the record Patient E's condition and the fetus' condition throughout labor and delivery.

SPECIFICATIONS OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence, within the meaning of N.Y. Educ. Law Section 6530 (4)(McKinney's Supp. 1994), in that Petitioner charges the following:

1. The facts in paragraph A, A1 through A6.

2. The facts in paragraph B, B1 through B6.

3. The facts in paragraph C, C1 through C4.

4. The facts in paragraph D, D1 through D7.

5. The facts in paragraph E, E1 through E5.

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion, within the meaning of N.Y.Educ. Law Section 6530 (3)(McKinney's Supp. 1994), in that Petitioner charges two or more of the following:

6. The facts in paragraphs A and A1 through A6; B and B1 through B6; C and C1 through C4; and D and D1 through D7; and/or E and E1 through E4.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence, within the meaning of N.Y. Educ. Law Section 6530

(6)(McKinney's Supp. 1994), in that Petitioner charges the following:

7. The facts in paragraph A, A1 through A6.

8. The facts in paragraph B, B1 through B6.

9. The facts in paragraph C, C1 through C4.

10. The facts in paragraph D, D1 through D7.

11. The facts in paragraph E, E1 through E5.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion, within the meaning of N.Y. Educ. Law Section 6530 (5)(McKinney's Supp. 1994), in that Petitioner charges two or more of the following:

12. The facts in paragraphs A and A1 through A6; B and B1 through B6; C and C1 through C4; D and D1 through D7; and/or E and E1 through E4.

THIRTEENTH THROUGH SEVENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, within the meaning of N.Y.Educ. Law Section 6530 (32) (McKinney's Supp. 1994), in that Petitioner charges the following:

13. The facts in paragraphs A and A1, A2, A3, A4, and/or A5.

14. The facts in paragraphs Band B1, B2, B3, B4, and/or B5.

15. The facts in paragraphs C and C1, C2, and/or C4.

16. The facts in paragraphs D and D1, D2, and/or D5.

17. The facts in paragraphs E and E5.

DATED: New York, New York
December 7, 1994

Redacted Signature

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct