PUBLIC

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

July 5, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert James Laudicino, M.D.
13214 Lost Key Place
Bradenton, Florida 34202

Bill Vaslas, Esq.
Vaslas, Lepowsky, Hauss & Danke, LLP
201 Edward Curry Avenue, Suite 200
Staten Island, New York 10314

Paul Stein, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Robert James Laudicino, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-49) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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.

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

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

In the Matter of

Robert James Laudicino, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 06-49

Before ARB Members Grossman, Lynch, Pellman, Wagle and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Paul Stein, Esq.**
For the Respondent: **Bill Vaslas, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced with negligence on more than one occasion and failed to maintain accurate medical records. The Committee voted to censure and reprimand the Respondent and to require that he complete Continuing Medical Education (CME) courses. In this proceeding pursuant to N.Y. Public Health Law (PHL) § 230-c (4)(a)(McKinney 2006), the Petitioner asks the ARB to modify that Determination by placing the Respondent on probation for three years. After reviewing the hearing record and the review submissions by the parties, the ARB overturns the penalty the Committee imposed and we vote to place the Respondent on probation for three years, under the terms that appear in the Appendix to this Determination.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated N. Y. Education Law (EL) §§ 6530(3-5) & 6530(32) (McKinney Supp. 2006) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,

- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion, and,
- failing to maintain accurate patient records.

The charges related to the care that the Respondent, an Obstetrician-Gynecologist, provided to two women, Patients A and B. The record refers to the Patients by initials to protect privacy.

The Committee dismissed charges that the Respondent practiced with gross negligence or with incompetence on more than one occasion. The Committee also dismissed the charge that the Respondent failed to maintain an accurate record for Patient B. The Committee sustained the charges that the Respondent practiced with negligence on more than one occasion in treating Patients A and B and the Committee sustained the charge that the Respondent failed to maintain an accurate record for Patient A.

The Respondent treated Patient A in November and December 2001, after the Patient presented at the Emergency Room (ER) at St. Vincent's Hospital-Staten Island, complaining of cramping and vaginal spotting. The question concerning the Patient's condition centered on whether the Patient's symptoms indicated a spontaneous miscarriage or an ectopic pregnancy. An ectopic pregnancy (a pregnancy that develops somewhere other than the uterus) puts the Patient at risk for uncontrolled bleeding, and in some cases death from hemorrhage. The Respondent performed a Dilation and Curettage on Patient A on December 5, 2001 and sent tissue specimens to pathology. The Pathology Report on December 10, 2001 indicated "No chorionic villi are noted suggest follow-up". The Respondent indicated at hearing that he failed to read that portion of the Pathology Report. The Committee concluded that the pathology finding of no villi raised the possibility of an ectopic pregnancy. The Committee found that the Respondent failed to follow accepted medical standards by failing to follow-up with Patient A. The Patient eventually entered New York-Presbyterian Hospital on January 2, 2002, with presenting symptoms of pelvic pain. Surgery at that time revealed an ectopic pregnancy. Patient A later called the Respondent's office with a complaint. The Committee found that the Respondent failed to maintain an accurate medical record for Patient A, because the Patient's record failed to list the call and complaint.

The Committee found that the Respondent provided pre-natal care to Patient B and delivered Patient B's baby in October 2002. In February 2002, the Respondent performed a test on the Patient for Hepatitis C. The test proved positive. From the time the test proved positive until the date the Patient delivered, the Respondent failed to:

- inform the Patient,
- order a confirmatory test,
- refer the Patient to a specialist,
- develop a treatment plan for Hepatitis C, and,
- counsel the Patient.

The Respondent blamed those failures on the mechanism in his office for notifying patients about abnormal test results. The Respondent argued that he ordered corrective measures in the office notification system after the breakdown concerning Patient B.

The Committee voted 2-1 to censure and reprimand the Respondent and to order the Respondent to complete CME courses in practice management and risk management. The Committee concluded that the Respondent's failure to review laboratory findings for Patients A and B resulted from the Respondent being overextended in his practice and from insufficient time to review and discuss findings, inadequate office mechanisms to process medical reports and inadequately trained office staff. The dissenting member of the Committee voted to suspend the Respondent's License to practice medicine in New York State (License) for six months, in addition to voting to require the Respondent to complete the CME courses.

Review History and Issues

The Committee rendered their Determination on March 8, 2006. This proceeding commenced on March 24, 2006, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's reply brief. The record closed when the Respondent filed the reply brief on or about May 8, 2006.

The Petitioner challenges the Committee's conclusion that the Respondent's departures resulted from system failures in the Respondent's practice. The Petitioner argues that the Respondent bore direct responsibility for misreading the pathology report for Patient A. The Petitioner requests that the ARB overturn the Committee and place the Respondent on probation, with a practice monitor for at least three years.

The Respondent argues that the Petitioner requests a draconian penalty. The Respondent argues that even though the Hearing Committee dismissed gross negligence and incompetence charges, the Petitioner requests a penalty consistent with those dismissed charges. The Respondent requests that the ARB refuse to substitute the desires of the Petitioner for the findings of the Hearing Committee.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even

without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. The ARB affirms the Committee's Determination that the Respondent practiced with negligence on more than one occasion in treating Patients A and B and that the Respondent failed to maintain an accurate medical record for Patient A. Neither party challenged the Committee's Determination on the sustained charges. We overturn the Committee's Determination censuring and reprimanding the Respondent and ordering that he complete CME courses. The ARB votes to place the

Respondent on probation for three years under the terms that appear at the Appendix to this Determination.

We find the Committee's Determination to order CME inappropriate. Continuing education represents an appropriate penalty in a case in which a Committee finds incompetence, or the lack of skill or training necessary to practice medicine safely. This Committee, however, dismissed the incompetence charges against the Respondent. The Committee also noted that the Respondent's failures may have resulted from office failures, but the Committee noted that the Respondent had taken steps to address office problems.

The record demonstrates that the Respondent failed to follow accepted practice standards by failing to review completely or follow up on laboratory reports. The ARB concludes that probation, with a monitor to review the Respondent's charts periodically, provides the proper means to assure that the Respondent has corrected the deficiencies in his practice. We find nothing draconian in such review over the Respondent. We note also from the record that the Respondent has been away from practice for a time, which raises further concerns about how well the Respondent might focus on his patients if he chooses to return to practice at some point.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB overturns the Committee's Determination to censure and reprimand the Respondent and to order that the Respondent complete Continuing Medical Education courses.
3. The ARB places the Respondent on probation for three years under the terms that appear in the Appendix to this Determination. The probation shall commence running on the date that the Respondent re-activates his License.

Robert M. Briber
Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Robert James Laudicino, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Laudicino.

Dated July 1, 2006

Robert M. Briber

In the Matter of Robert James Laudicino, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Laudicino.

Dated: July 3, **2006**

Thea Graves Pellman

Thea Graves Pellman

In the Matter of Robert James Laudicino, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Laudicino.

Dated: 7/11, **2006**

Datta G. Wagle, M.D.

In the Matter of Robert James Laudicino, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Laudicino.

Dated: June 29, 2006

S L Grossman M.D

Stanley L Grossman, M.D.

In the Matter of Robert James Laudicino, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Laudicino.

Dated: July 3, 2006

Therese G. Lynch M.D

Therese G. Lynch, M.D.

Appendix

Terms of Probation

1. The Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. The Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River St.-Suite 303, Troy, New York 12180 to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. The Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of the Respondent's compliance with the terms of this Order. The Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The Respondent shall practice medicine only when monitored by a licensed physician, board certified in Obstetrics/Gynecology, ("practice monitor") proposed by the Respondent and subject to the written approval of the Director of OPMC.

a. The Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. The Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. The Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. The Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

5. The period of probation shall be tolled during periods in which the Respondent is not engaged in the active practice of medicine in New York State. The Respondent shall notify the Director of OPMC, in writing, if the Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. The Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. The Respondent shall maintain legible and complete medical records, which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. The Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.