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STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

March 8, 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 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.

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 Respondent or the Department may seek a review of a committee determination.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER

OF

ROBERT JAMES LAUDICINO, M.D.

DETERMINATION

AND

ORDER

BMPC #06-49

MICHAEL R. GOLDING, M.D., Chairperson, **CASSANDRA E. HENDERSON, M.D.**, and **CONSTANCE GARROW DIAMOND, D.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges charges the Respondent with professional misconduct by practicing the profession of medicine with gross negligence on a particular occasion (one specification) and with negligence on more than one occasion (one specification), by practicing the profession of medicine with incompetence on more than one occasion (one specification), and by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (two specifications).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	August 18, 2005
Date of Service of Notice of Hearing and Statement of Charges:	August 26, 2005[1]
Answer to Charges Dated:	August 30, 2005
Prehearing Conference Date:	September 14, 2005
Hearing Dates:	September 21, 2005 November 4, 2005 November 18, 2005
Deliberation Date:	January 4, 2006
Place of Hearing:	NYS Department of Health 90 Church Street, 4th Floor New York, New York
Petitioner Appeared By:	Paul Stein, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Vaslas Lepowsky Hauss & Danke, LLP 201 Edward Curry Avenue, Suite 200 Staten Island, N.Y. 10314 By: Bill Vaslas, Esq.

[1] See Affidavit of Service included in Petitioner's Exhibit 1.

WITNESSES

For the Petitioner:	Elisa E. Burns, M.D. Nicolle Cobos
For the Respondent:	Robert James Laudicino, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Robert James Laudicino, M.D. ["the Respondent"] was authorized to practice medicine in New York State on September 17, 1984 by the issuance of license number 160076 by the New York State Education Department (Prehearing Conference Tr. 35-36; Ex. 2).
2. The Respondent attended medical school at the University of Guadalajara in Mexico (1973-1976), where he received his M.D. Degree (Tr. 196).
3. The Respondent received postgraduate medical training in Obstetrics and Gynecology ["OB-GYN"]. More specifically, he did a first and second year OB-GYN at New York Medical College (1978-1980); a third year OB-GYN and chief residency at Long Island College Hospital (1980-1982); and, a teaching fellowship in Gynecology at Long Island College Hospital (1982-1984). (Tr. 196-197 and 213-214).

4. In 1984 the Respondent went into private practice with Dr. Joseph Shamphy. In 1986 Dr. Shamphy died and the Respondent began his own practice. The Respondent remained in private practice until December 2003. (Tr. 197-198).

5. During the course of his career the Respondent developed an expertise in laparoscopic surgery. Over the years he performed in the neighborhood of 3,000 to 4,000 laparoscopic procedures. (Tr. 198-200).

6. In the years 2000 and 2001 the Respondent had a very active and busy OB-GYN practice. In an average week he saw between 200 and 225 patients and performed 15 to 16 surgeries. He used to deliver approximately 300 babies per year, but by 1998 he cut down the number of deliveries to approximately 175 per year. He worked between 110 and 115 hours per week and he didn't have any partners. (Tr. 200-201 and 226-227).

7. The Respondent performed most of his laparoscopic surgeries at Bayley Seton Hospital in Staten Island, New York, and all other major surgeries at St. Vincent's Hospital in Staten Island, New York. (Tr. 222-223).

8. The Respondent is not Board Certified. He took the written boards three times, but never passed. (Tr. 214-215).

9. Finally, the Respondent has been retired since December 2003 and is not currently practicing medicine (Tr. 198 and 204-205).

SPECIFIC FINDINGS AS TO EACH PATIENT

Patient A

10. From on or about November 15, 2001 through in or about December 2001 the Respondent treated Patient A, a 26 year-old female, at his office at 4131 Richmond Avenue, Staten Island, New York, and at St. Vincent's Hospital - Staten Island ["St. Vincent's"] at 355 Bard Avenue, Staten Island, New York. (Tr. 40-132 and 245-319; Exs. 4 and 6).

11. On December 4, 2001 Patient A presented to the Emergency Room at St. Vincent's complaining of cramping and vaginal spotting for two days (Tr. 43-44; Ex. 4, p. 23).

12. The impression of the Emergency Room physician was ectopic pregnancy. Patient A was then admitted for observation with the impression of miscarriage, cannot rule out ectopic. (Tr. 44 and 48-49; Ex. 4, pp. 25 and 35).

13. On December 4, 2001, after Patient A was admitted to the hospital, a pelvic ultrasound and a transvaginal ultrasound were performed on the patient, and no intrauterine gestation was found. The ultrasound report was dictated on December 6, 2001 and printed on December 7, 2001. (Tr. 44-47; Ex.4, pp. 11-12).

14. The Respondent failed to adequately diagnose and treat Patient A (Tr. 68-69; Exs. 4 and 6).

15. On December 5, 2001 the Respondent noted in the patient's chart "Assessment plan: Rule out ectopic; less likely. Probably missed AB. Appointment sono., CBC this a.m." (Tr. 49; Ex. 4, p. 36).

16. On December 5, 2001 the Respondent performed a Dilation and Curettage ["D&C"] and an examination under anesthesia on the patient. The preoperative diagnosis was incomplete abortion. The postoperative diagnosis was also incomplete abortion. (Tr. 50-51; Ex. 4, p. 19).

17. Later that day, on December 5, 2001, the patient was sent home with instructions to see the Respondent at his office for a follow-up (Tr. 51; Ex. 4, p. 41).

18. The Respondent sent the tissue specimen obtained during the patient's D&C to pathology (Tr. 53; Ex. 4, p. 20).

19. Patient A's pathology report dated December 10, 2001 stated, in part, "No chorionic villi are noted suggest following-up." (Tr. 53-54; Ex. 4, p. 20).

20. Since no villi were found, the location of the pregnancy could not be ascertained with complete certainty (Tr. 54; Ex. 4, p. 20 and Ex. 6, p. 7).

21. Although it is possible that Patient A had had a spontaneous miscarriage, there was no evidence to support that possibility (Tr. 54; Ex. 4, p. 20 and Ex. 6, p. 7).

22. The Respondent is responsible for following up and making sure that the results of the pathology are obtained and that he is aware of them. The Respondent should have done that by calling the pathology department. (Tr. 55-56).

23. The Respondent admitted that he did not read the second part of the pathology report which stated "No chorionic villi are noted *". The Respondent admitted that this failure was just "human error" on his part. (Tr. 275; Ex. 4, p. 20 and Ex. 6, p. 7).

24. The Respondent's failure to follow up on Patient A's pathology report constitutes a departure from acceptable medical standards. More specifically, the failure to follow up this patient with a beta HCG level following her discharge from the hospital was the

actual departure from the standard of care, given the pathology report showing no villi found. The pathology report needed to be obtained as soon as possible. In addition, if there was a concern about the location of the pregnancy, a follow-up beta HCG needed to be obtained, perhaps by December 6, 2001 or December 7, 2001. Furthermore, the Respondent should have contacted Patient A to see her within the next few days after the surgery. (Tr. 69, 111-113 and 119-120; Ex.. 4, p. 20).

25. The two most likely explanations for the findings that appear in the pathology report are a miscarriage that had already completed or an ectopic pregnancy (Tr. 107; Ex. 4, p. 20).

26. In order to establish whether the patient had a completed abortion or an ongoing ectopic pregnancy, the Respondent should have drawn serial beta HCG levels, usually every other day, and the results would determine whether another HCG level was needed (Tr. 107-108).

27. There is no indication in the Respondent's office record for Patient A that there was a postoperative office visit. Furthermore, there was no postoperative beta HCG test ordered by the Respondent and no postoperative pelvic sonogram ordered or taken by the Respondent. (Tr. 57 and 68; Ex. 6).

28. However, on January 2, 2002 Patient A saw another physician, Dr. Richard Levine, at New York-Presbyterian Hospital, with a presenting symptom of pelvic pain. "Positive beta HCG with hemoperitoneum" was noted as history of present illness. (Tr. 61-62; Ex. 5, pp. 10-13).

29. Dr. Levine's diagnosis was an ectopic pregnancy (Tr. 62-63; Ex. 5, p. 13).

30. Later that day, on January 2, 2002, Patient A was taken to the operating room at New York-Presbyterian Hospital where she underwent a left salpingectomy for a left tubal pregnancy. The final diagnosis was left ectopic pregnancy. (Tr. 63-64; Ex. 5, pp. 25-27).

31. An ectopic pregnancy is a pregnancy that develops somewhere other than within the uterus. The primary risk of an ectopic pregnancy is that the patient can have uncontrolled bleeding from the pregnancy developing in the wrong place. The ultimate outcome can be death from hemorrhage, which happens in some cases. Delay in diagnosis is the primary reason for hemorrhage. However, if the diagnosis of ectopic pregnancy is made promptly, the vast majority of patients do well with surgical or medical treatment. (Tr. 64-66).

32. Patient A called the Respondent's office with a complaint some time after the surgery. The Respondent does not remember what the complaint was. In addition, neither the call nor the complaint was recorded in the Respondent's office record for Patient A. (Tr. 268-269 and 294-295; Ex. 6).

33. The Respondent's failure to record the patient's phone call and complaint constitutes a departure from acceptable medical practice (Tr. 72). [2-1 vote].

Patient B

34. From on or about February 19, 2002 through on or about November 6, 2002 the Respondent treated Patient B, a 31 year-old female, at his office at 4131 Richmond Avenue, Staten Island, New York, and at Staten Island University Hospital ["SIUH"] at 475 Seaview Avenue, Staten Island, New York. (Tr. 133-174 and 320-360; Exs. 7 and 11).

35. The Respondent and his staff provided prenatal care to Patient B throughout her uneventful pregnancy (Tr. 375-376; Ex. 7).

36. On October 15, 2002 the Respondent delivered Patient B's baby by Cesarean section at SIUH. It was an unremarkable delivery. (Tr. 135-136 and 376; Ex. 11, pp. 40-42).

37. On February 25, 2002, almost eight months before the delivery, the Respondent performed a hepatitis C test on Patient B, which was reported as positive on February 27, 2002 (Tr. 134-136; Ex. 7, p. 12).

38. A hepatitis C blood test is not a standard test performed during prenatal care and is not routinely ordered (Tr. 169-170).

39. It is not appropriate to treat a patient who is pregnant for hepatitis C, since the necessary medications are not approved for use in pregnant women (Tr. 136-137).

40. Prior to the date of the delivery neither the Respondent nor anyone else in his office told Patient B that she was hepatitis C positive (Tr. 137 and 376-378; Ex. 7).

41. Patient B did not know that she was hepatitis C positive until the date of her delivery, October 15, 2002. She first learned about being hepatitis C positive after she arrived at the hospital, when the doctor who was prepping her for the Cesarean section told her that her chart indicated that she was hepatitis C positive. (Tr. 376-378 and 389-391).

42. The Respondent's failure to inform Patient B that she was hepatitis C positive prior to the date of her delivery was a departure from the standard for acceptable medical care. This failure deprived Patient B of important information about her own personal health and the need to take preventive measures to protect her marital partner from the possible transmission of the virus. Furthermore, the emotional impact of learning that she was hepatitis C positive was significantly increased by the fact that she first learned this

disturbing information immediately before undergoing a Cesarean section. (Tr. 137-140, 376-378 and 390-391; Ex. 7).

43. Hepatitis C is usually transmitted through bodily fluids or blood transfusions, and can also be transmitted sexually (Tr. 138).

44. Patient B was married and there was a risk that her husband could contract the hepatitis C virus from her (Tr. 138-139 and 374-375).

45. After the delivery, Patient B followed up with Gerald Dimaso, M.D., who ordered additional blood work that indicated that the patient was infected with hepatitis C (Tr. 167 and 378-379; Ex. 10A, pp. 2-5).

46. Patient B subsequently saw Joseph A. Odin, M.D., a specialist in liver diseases, at Mount Sinai School of Medicine, who treated her for the hepatitis C (Tr. 379-380 and 382-383; Ex. 8 and Ex. 10A, pp. 11-12).

47. The Respondent failed to adequately evaluate Patient B (Tr. 145-146; Ex. 7). [2-1 vote].

48. With respect to the hepatitis C, the Respondent should have first ordered confirmatory laboratory tests of the hepatitis C positive finding and, if confirmed, he should have then referred the patient to a gastroenterologist (Tr. 145).

49. The Respondent did not order confirmatory laboratory tests of the hepatitis C positive finding. Furthermore, neither the Respondent nor anyone else from his office ever referred Patient B to a gastroenterologist or any other specialist for her hepatitis C. (Tr. 380-381; Ex. 7).

50. In addition, the Respondent failed to develop an adequate treatment plan for Patient B. Even though there was a plan for the delivery, there was no treatment plan with regard to the hepatitis C. (Tr. 146 and 380-381; Ex. 7).

51. Furthermore, the Respondent failed to adequately counsel Patient B. Although he told her on the date of the delivery that the hepatitis C finding could be a false positive and that she should follow up with her regular doctor, there is no evidence of any counseling. (Tr. 146, 391-392 and 398-399; Ex. 7).

52. Patient B returned to the Respondent's office only once after the delivery, to have her stitches removed. At that time she saw the midwife, not the Respondent, and the hepatitis C finding was not mentioned. (Tr. 380 and 398-399; Ex. 7).

53. The Respondent failed to document fundal height, presentation, and fetal movement in Patient B's prenatal record (Tr. 141-142; Ex. 7, p. 4).

54. Despite this failure to document fundal height, presentation, and fetal movement, the Respondent's medical record for Patient B was adequate (Tr. 148-153 and 351-352; Ex. 7). [2-1 vote].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patient A, 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.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A and B, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A and/or B.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patient A, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of Patient A [2-1 vote]. However, the Petitioner has failed to prove by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patient B, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of Patient B [2-1 vote].

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of Elisa E. Burns, M.D., and the factual testimony of Patient B, in its efforts to establish its case against the Respondent. While Dr. Burns testified with regard to the Respondent's medical care and treatment of Patients A and B, Patient B testified about the medical care and treatment that she received from the Respondent and members of his staff.

As its first witness the Petitioner presented Elisa E. Burns, M.D., as an expert in the field of OB-GYN. Dr. Burns attended medical school at Columbia University, College of Physicians and Surgeons, New York, N.Y. (1978-1982), where she received her M.D. Degree. After graduating medical school she received postgraduate medical training in OB-GYN at the Department of Obstetrics and Gynecology at Columbia Presbyterian Medical Center, New York, N.Y., where she served as a Resident (1982-1985) and Chief Resident (1985-1986). (Tr. 32; Ex. 3).

Dr. Burns is affiliated with Northern Westchester Hospital Center in Mount Kisco, N.Y., where she currently serves as Chief of the Department of Obstetrics and Gynecology (1993-present) and as an Attending Physician (1986-present). She is also affiliated with Mount Kisco Medical Group, P.C., in Mount Kisco, N.Y., where she serves as an Obstetrician-Gynecologist (1986-present). In addition, she belongs to various professional organizations, including American College of Obstetricians and Gynecologists, Planned Parenthood Westchester/Rockland, and Westchester Obstetrical and Gynecological Society. Finally, in 1988 she received Board Certification in Obstetrics and Gynecology and was recertified in 1998. (Tr. 31-33 and 37; Ex. 3).

The Hearing Committee found Dr. Burns to be a convincing and credible witness. She was straightforward, non-evasive, knowledgeable and her testimony was balanced and unbiased. Her credentials are impressive and she demonstrated a far-reaching command of the field of Obstetrics and Gynecology.

Following the testimony of Dr. Burns, the Petitioner presented Patient B as its final witness. The Hearing Committee found Patient B to be honest, sincere, straightforward, non-evasive and unbiased. The Hearing Committee believed her and found her testimony credible.

The Respondent's case relies primarily on the medical and factual testimony of the Respondent, who was the only witness to testify in support of the Respondent's case. The Respondent has extensive experience in Obstetrics and Gynecology, having specialized in this area throughout his entire professional career. The Respondent had maintained a private OB-GYN practice since 1984. Although he had a partner for the first two years of his practice, his partner died and he continued to work as a sole practitioner. As time went by the practice grew.

As the practice grew the Respondent saw more patients and worked longer hours. By the year 2000 the Respondent was engaged in a very busy, high volume OB-GYN practice. In December 2003 he closed his practice and retired. He is not currently practicing medicine. (See findings 1 through 9, *supra*).

The Respondent testified at length in his own behalf. It is beyond dispute that the Respondent is an interested witness who will be directly affected by the outcome of this hearing. Nevertheless, it was noted that throughout the hearing 1) the Respondent freely acknowledged his failures and mistakes in connection with the care and treatment provided to Patients A and B, and 2) he accepted full responsibility for such failures and mistakes. For example, when the Respondent was first questioned about Patient A's pathology report, he admitted that he only read the first part of the report, that he never read the second part, and that that was a mistake (Tr. 217 and 262-264). Another example occurred while he was being questioned about the failure to notify Patient B that she had a positive hepatitis C test. More specifically, he admitted that on the date of delivery Patient B told him that she had never been informed that she tested positive for hepatitis C, and that that was the first time that he ever discussed the positive hepatitis C finding with her (Tr. 333-334 and 337). He also admitted that if she did not know about the hepatitis C finding until the date of her delivery, the mechanism that he had in his office for notifying a patient of abnormal test results just did not work (Tr. 334). After recognizing that the problem was caused by a breakdown of the office notification mechanism, the Respondent accepted responsibility for the functioning of his office (Tr. 342-343). In fact, as soon as he learned about this breakdown, he initiated corrective measures to address the

notification problem and to prevent its reoccurrence. Under the new office procedure, any abnormality appearing in a test is to be brought to the Respondent's personal attention and the Respondent then handles the particular matter himself. (Tr. 217-220, 335-336 and 342-344).

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

The Respondent deviated from acceptable medical standards in connection with the care and treatment that he provided to Patients A and B. Consequently, the Hearing Committee found the Respondent negligent in connection with the medical care and treatment that he provided to each of these patients. Although the Hearing Committee found the Respondent negligent in connection with the medical care and treatment that he provided to Patient A, the Hearing Committee does not believe that any of the proven allegations of negligence relating to Patient A is egregious and conspicuously bad, and thereby rises to the level of gross negligence.

In addition, the Respondent did not lack the requisite skill or knowledge to practice medicine in connection with the care and treatment that he provided to Patients A and B. Consequently, the Hearing Committee found that the Respondent was not incompetent in connection with the medical care and treatment that he provided to each of these patients.

Finally, the resolution of the recordkeeping issues required an examination of the entries made by the Respondent in the medical records for each patient as well as an evaluation of the medical testimony relating to the adequacy of each of these medical records.

The Respondent failed to maintain records for Patient A that accurately reflect his evaluation and treatment of Patient A [2-1 vote]. Consequently, the majority of the Hearing Committee found that the Respondent failed to maintain adequate medical records for Patient A.

However, the Respondent did maintain records for Patient B that accurately reflect his evaluation and treatment of Patient B [2-1 vote]. Consequently, the majority of the Hearing Committee found that the Respondent did maintain adequate medical records for Patient B.

Discussion of the Treatment of the Patients

The medical care and treatment of Patient A was compromised by the Respondent's failure to read the complete pathology report that had been prepared in connection with the patient's D&C. The Respondent only read the first part of the report, which supported his initial impression that the patient had a miscarriage. However, he didn't read the second part that indicated no villi found, which raised the possibility of an ectopic pregnancy. This misreading of the report could have been fatal to the patient. Fortunately, it wasn't.

The medical care and treatment of Patient B was tainted by the Respondent's failure to inform her that she had tested positive for hepatitis C. Patient B did not learn that she was hepatitis C positive until she was about to give birth, almost eight months after the test results were reported to the Respondent. Furthermore, neither the Respondent nor any member of his staff ever discussed with the patient the significance of the hepatitis C finding and the available options.

Either the Respondent or a member of his staff should have 1) promptly notified Patient B that she had tested positive for hepatitis C, and 2) discussed with her the significance of this finding and the available options. The fact that it is inappropriate to treat a patient who is pregnant for hepatitis C, is no excuse for this failure. In addition, although a hepatitis C blood test is not routinely ordered during prenatal care, once ordered, it is incumbent open the physician who ordered the test to act upon the results. If a test is ordered and the patient is not informed of the results, the patient usually assumes that the results are normal. In other words, most patients generally believe "no news is good news". A physician's failure to notify a patient of test results, in effect, lulls the patient into a false sense of security and thereby increases risk to the patient.

As the hearing progressed it became apparent to the Hearing Committee that the Respondent was overextended and he didn't have efficient and effective office mechanisms and staff to adequately support his high volume practice. Moreover, it was observed that the sustained negligence charges involved inadequate and/or inappropriate review of laboratory findings appearing in medical reports. The likely source of this failure was 1) insufficient time to review and discuss the particular findings, 2) inadequate office mechanisms to process the medical reports, and 3) inadequately trained office support staff. In addition, the office support staff was poorly supervised and there was no clear description of job responsibilities. The absence of a clear delineation of job responsibilities facilitates redundancies, confusion, errors, failures of communication, and omissions. (Tr. 230 and 234-236).

The Hearing Committee believes that the two matters which are the subject of this hearing resulted from office system failures. However, these system failures are attributed to the Respondent who created the system. More specifically, the Respondent created an office environment that had a negative impact on communication and the flow of information between the Respondent, the individual members of his staff, and his patients.

In the final analysis, the Respondent bears the ultimate responsibility for the functioning of his office. Consequently, the Respondent is responsible for the failures and deficiencies of his office mechanisms and supporting staff.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

A	Sustained	
A1	Sustained	
A2	Sustained	[2-1 vote][2]

Factual Allegations relating to the treatment of Patient B

B	Sustained	
B1	Sustained	[2-1 vote]
B2	Sustained	
B3	Sustained	
B4	Not Sustained	[2-1 vote][3]

[2] While the majority of the Hearing Committee believes that the failure to document the phone call and complaint made by the patient to the Respondent's office some time after her delivery, is sufficient, in and of itself, to sustain the recordkeeping specification, the dissenting member disagrees and believes that the recordkeeping specification with respect to Patient A should not be sustained.

Specifications

Gross Negligence

1st Specification (Treatment of Patient A) Not Sustained

Negligence on More than One Occasion

2nd Specification Sustained

Sustained Factual Allegations in Support of the 2nd Specification:

Treatment of Patient A: A, A1 and A2

Treatment of Patient B: B, B1, B2 and B3

Incompetence on More than One Occasion

3rd Specification (Treatment of Patients A and B) Not Sustained

Failure to Maintain Records

4th Specification (Medical Record of Patient A) Sustained [2-1 vote][4]

Sustained Factual Allegations in Support of the 4th Specification: A and A2

5th Specification (Medical Record of Patient B) Not Sustained [2-1 vote][5]

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[3] While the dissenting member of the Hearing Committee believes that the failure to document fundal height, presentation, and fetal movement, is sufficient, in and of itself, to sustain the recordkeeping specification, the majority disagrees and believes that the recordkeeping specification with respect to Patient B should not be sustained.

[4] See Note 2, *supra*.

[5] See Note 3, *supra*.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, hereby determines, by a vote of two to one, that the Respondent should receive a penalty of Censure and Reprimand. In addition, the Hearing Committee unanimously determines that the Respondent should be required to enroll in and complete 1) a Continuing Medical Education Course in the area of Office Practice Management, and 2) a Continuing Medical Education Course in the area of Risk Management, conducted by or on behalf of the American College of Obstetricians and Gynecologists.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

Although the dissenting member of the Hearing Committee voted with the majority in requiring the Respondent to enroll and complete Continuing Medical Education Courses in the areas of Office Practice Management and Risk Management, the dissenting member voted against a Censure and Reprimand penalty. The dissenting member voted in favor of a straight six months Suspension of the Respondent's medical license.

The Hearing Committee unanimously concluded that the Respondent's conduct was unacceptable. However, the Hearing Committee believes that the Respondent appreciates the seriousness of his failures and mistakes. Additionally, the Hearing Committee noted that the Respondent had instituted changes in the operation of his office to address his failures and mistakes and prevent their reoccurrence.

The Hearing Committee recognizes that its primary responsibility is to protect the public. The majority of the Hearing Committee firmly believes that it is fulfilling this responsibility by imposing a penalty of Censure and Reprimand with Continuing Medical Education in Office Practice Management and Risk Management. It does not believe that the Respondent presents a threat to the public.

The Hearing Committee observed that the gross negligence and incompetence charges were not substantiated and those misconduct charges that were substantiated – ordinary negligence and failure to maintain records - related primarily to system failures in connection with the operation of the Respondent's office. Since the Respondent's primary deficiency is connected to the way in which he runs his office, supplemental training in Office Practice Management and Risk Management would enable the Respondent to overcome his shortcomings and continue to provide an important service to the community.

The Hearing Committee was impressed with Patient B's candor when she stated that, putting aside the mishap relating to the hepatitis C test, she was satisfied with the care that she received from the Respondent and that he was attentive to her concerns and complaints (Tr. 383-384). The Hearing Committee is also mindful of the fact that because the Respondent had a practice of routinely ordering hepatitis C blood tests, Patient B was diagnosed as having hepatitis C and treated for her hepatitis C earlier than she otherwise would have (Tr. 173-174). Although

this fact does not excuse the Respondent's failure to notify Patient B about the positive hepatitis C finding, she clearly benefited from this practice.

Given the totality of the circumstances regarding this matter and the fact that the Respondent's primary problem is a management problem, the majority of the Hearing Committee believes that neither revocation, suspension nor probation is warranted.

Finally, the majority of the Hearing Committee believes that in view of all the circumstances, a Censure and Reprimand together with a requirement for supplemental training in Office Practice Management and Risk Management, is an appropriate penalty commensurate with the seriousness of the proven misconduct.

ORDER

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

1. The 2nd and 4th Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The 1st, 3rd and 5th Specifications of professional misconduct contained within the Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent is hereby **CENSURED and REPRIMANDED**; and

4. The Respondent shall enroll in and complete a **CONTINUING MEDICAL EDUCATION COURSE** in the area of Office Practice Management and a **CONTINUING MEDICAL EDUCATION COURSE** in the area of Risk Management ("the CME Courses"), conducted by or on behalf of the American College of Obstetricians and Gynecologists; the CME Courses shall be subject to the prior written approval of the Director of the Office of Professional Medical Conduct ("the Director") who has offices at Hedley Park Place, 433 River Street, Suite 303, Troy, New York 12180; and, the CME Courses shall be completed within one hundred eighty (180) days of the effective date of this Order, unless the Director approves an extension in writing; and

5. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York
March 07, 2006

MICHAEL R. GOLDING, M.D.
Chairperson

CASSANDRA E. HENDERSON, M.D.
CONSTANCE GARROW DIAMOND, D.A.

TO: ROBERT JAMES LAUDICINO, M.D.
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APPENDIX I

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

IN THE MATTER OF ROBERT JAMES LAUDICINO, M.D.	STATEMENT OF CHARGES

ROBERT JAMES LAUDICINO, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 17, 1984, by the issuance of license number 160076 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about November 15, 2001 through in or about December, 2001, Respondent treated Patient A (all patients are identified in Appendix A below) in his offices at 4131 Richmond Avenue, Staten Island, New York and at St. Vincent's Hospital Staten Island, 355 Bard Avenue, Staten Island, New York.

1. Respondent failed to adequately diagnose and treat Patient A.
2. Respondent failed to keep an adequate record for Patient A.

B. From on or about February 19, 2002 through on or about November 6, 2002, Respondent treated Patient B in his offices at 4131 Richmond Avenue, Staten Island, New York and at Staten Island University Hospital, 475 Seaview Avenue, Staten Island, New York.

1. Respondent failed to adequately evaluate Patient B.
2. Respondent failed to adequately counsel Patient B.
3. Respondent failed to develop an adequate treatment plan for Patient B.
4. Respondent failed to keep an adequate record for Patient B.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

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

1. Paragraph A and A1-2.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A and A1-2 and/or B and B1-4.

THIRD SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

3. Paragraphs A and A1-2 and/or B and B1-4.

FOURTH AND FIFTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

4. Paragraphs A and A2.

5. Paragraphs B and B4.

DATED: New York, New York
August 18, 2005

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct