STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

December 7, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

James R. Caputo, M.D.

Redacted Address

Michael Paul Ringwood, Esq.
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Syracuse, New York 13202-1252

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

RE: In the Matter of James R. Caputo, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-271) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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,

Redacted Signature
James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
JAMES R. CAPUTO, M.D.	:	ORDER
		BPMC #07-271

A Notice of Hearing and Statement of Charges, both dated May 10, 2007, were served upon the Respondent, James R. Caputo, M.D. **CHARLES J. VACANTI, M.D.**, Chairperson, **RAJAN K. SRISKANDARAJAH, M.D.** and **JEAN KRYM**, 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. **WILLIAM J. LYNCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by **TIMOTHY J. MAHAR, ESQ.**, of Counsel. The Respondent appeared by SMITH, SOVIK, KENDRICK & SUGNET, P.C., **MICHAEL PAUL RINGWOOD, ESQ.**, of Counsel. 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:	May 11, 2007
Answer Filed:	June 8, 2007
Pre-Hearing Conference:	June 14, 2007
Hearing Dates:	June 22, 2007 July 27, 2007 August 17, 2007 August 20, 2007 August 21, 2007 August 27, 2007 August 28, 2007
Witnesses for Petitioner:	Robert C. Tatelbaum, M.D. David Brittain, M.D.* Patient F's spouse *
Witnesses for Respondent:	James R. Caputo, M.D. Frances Campbell, R.N. Teresa Monnett, R.N. Ronald Stahl, M.D. James Steven Burkhart, M.D.* Patient A * Patient B * Patient C *

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

* Transcribed testimony of these witnesses was entered into evidence.

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. James R. Caputo, M.D. ("Respondent") is charged with twenty specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). The charges relate to Respondent's medical care of six patients. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain records. A copy of the Notice of Hearing and 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 set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence

presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

1. James R. Caputo, the Respondent, was authorized to practice medicine in New York State on March 11, 1997, by the issuance of license number 206065 by the New York State Education Department (Ex. 2).

Patient A - 2001 delivery

2. On February 28, 2001, Patient A had her first prenatal visit with Respondent for her first pregnancy (Ex. 4, p. 3; T. 73).

3. Starting on September 7, 2001, Patient A had painful contractions (Ex. 4, p. 5; T. 75-76). These were Braxton Hicks contractions or false labor pains which were not causing her cervix to dilate (T. 76).

4. On September 12, 2001, Patient A was diagnosed with cellulitis in her right leg with a question of a deep vein thrombosis (Ex. 4, p. 5; T. 76). Patient A was admitted to Crouse Hospital and was treated with IV antibiotics (Ex. 5, p. 2; T. 77). The cellulitis condition improved during the hospitalization (T. 77).

5. On September 14, 2001, Patient A's cervix was noted to be 1 cm dilated, 50% effaced with the fetal vertex at -2 station. This cervical status change may have indicated the beginning of the latent phase of labor (Ex. 5, p. 78; T. 79-80).

6. On September 15, 2001, Patient A's cervix was 1 to 2 cm dilated, 50% effaced at -3 station with a bulging bag of waters (Ex. 5, p. 82; T. 80).

7. On September 15, 2001, Respondent artificially ruptured Patient A's membranes. The risks to Patient A's fetus of artificially rupturing her membranes included umbilical cord prolapse (T. 82-83). At -3 station the fetal head had not yet engaged in the maternal pelvis (T. 82).

8. Given the gestational age of Patient A's pregnancy at 37 and 2/7 weeks, her resolving cellulitis and her cervical status, the standard of care for managing Patient A on September 15, 2001 was to wait to see if she went into spontaneous labor so that the cervix could continue to dilate (T. 81-82). Respondent deviated from accepted standards of medical care when he ruptured Patient A's membranes (T. 88).

9. At the time Respondent ruptured Patient A's membranes, there were no medical indications for Respondent to do so (T. 87-88). Further, there was a risk of dysfunctional labor given a primagravida with a relatively unfavorable cervix (T. 89). Labor may not be stimulated by membrane rupture in these circumstances (T. 89).

10. Respondent artificially ruptured Patient A's membranes at 3:15 p.m. (Ex. 5, p. 145; T. 90). At 5:30 p.m., Patient A was given

Pitocin due to Patient A's dysfunctional labor (Ex. 5, p. 145). Dysfunctional labor occurs when contractions are ineffective in causing the cervix to dilate (T. 91). Pitocin corrects the dysfunctional contractions directing them from the top of the uterus towards the cervix (T. 92).

11. The fetal heart tracing of Patient A's fetus was acceptable at 1:00 a.m. on September 16, 2001 (T. 93-96); however, the tracing indicated a significant deceleration of the fetal heart rate to 60 bpm during the period between 1:00 a.m. and 1:06 a.m., (Ex. 6, p. 297).

12. After this deceleration, an internal scalp electrode was placed on the baby's head providing an EKG of the baby's heart rate, and a maternal intrauterine pressure catheter was inserted into the uterus to measure the contractions (T. 97-98; Ex. 6, p. 298).

13. Patient A's fetus experienced recurrent variable decelerations from 1:48 to 2:07 a.m. (Ex. 6, pp. 302-305; T. 107-108). These decelerations were abrupt in onset and abrupt in recovery, suggesting recurrent umbilical cord compression with each contraction (T. 108). Between the decelerations, the fetal heart rate showed variability, indicating that the fetus was receiving appropriate oxygen (T. 107). The variability seen following the

recovery from the deceleration suggested that the fetus was not significantly hypoxic (T. 108-109).

14. At approximately 1:00 a.m. on September 16, 2001, Patient A's fetus was in the occiput posterior position (T. 110; Ex. 5, p. 84). Occiput posterior is an unfavorable position for the fetus to deliver and often makes the second stage longer. Often the fetus will rotate spontaneously as it descends (T. 111).

15. At 1:06 a.m., Patient A's cervix was 5 to 6 cm dilated, 100% effaced and the fetus was at 0 station (T. 111-112). Patient A was given oxygen and placed on her left side (Ex. 5, p. 84). Both actions would potentially increase the oxygen to the fetus (T. 112). Respondent documented at the time that he anticipated a normal spontaneous vaginal delivery (Ex. 5, p. 84; T. 112). A spontaneous vaginal delivery is a non-instrumented delivery (T. 113).

16. Patient A became fully dilated at 2:15 a.m., and Respondent delivered a stillborn infant by forceps at 2:39 a.m.

17. The majority of primagravida patients who start with the fetus in the occiput posterior position spontaneously rotate and spontaneously deliver without the use of forceps (T. 131). Further, if these patients require delivery by forceps, there is a lower risk if they are allowed to push so that the fetus descends to a lower station (T. 132-133).

18. The indicated management of Patient A from a maternal standpoint given accepted standards of care would have been to instruct her to push, once she was fully dilated, to see if the fetus would descend and/or spontaneously rotate (T. 121-122).

19. There were no fetal indications for a forceps rotation and delivery (T. 122). Given the variable decelerations, the fetus needed to be observed closely as there was probably some cord compression during contractions (T. 122). The variability between the contractions suggested that the fetus was recovering appropriately (T. 122-123). If over time the condition of Patient A's fetus worsened, the obstetrician would not wait for Patient A to deliver spontaneously (T. 124). The decision would be to perform either a forceps delivery, vacuum delivery or a cesarean section (T. 124). However, indications for those procedures did not exist at the time Respondent applied the forceps in this case (T. 124).

20. It is only at the time of full cervical dilation that a patient is able to push (T. 126). This is commonly referred to as the second stage of labor (T.126). In this instance, Respondent applied the forceps at 2:15 a.m., the same time Patient A became fully dilated (T. 126).

21. The infant was delivered approximately five minutes after the arrival of the neonatology staff (Ex. 5, p. 97). The infant was

limp, pale, dusky, with no movement and no cry. Respondent placed the infant on Patient A's abdomen for one and a half to two minutes (Ex. 5, p. 97-99; T. 140-141). The infant was vigorously stimulated by Respondent who was milking the umbilical cord back towards the infant prior to allowing the father to cut the cord (T. 141). The resuscitative team received the infant at approximately one and a half minutes of age (Ex. 5, p. 99; T. 141).

22. The standard of care where an infant is limp, flaccid and non-responsive is to cut the umbilical cord as quickly as possible and transfer the infant to the pediatrician or neonatologist as quickly as possible so resuscitative efforts can begin immediately (T. 141-142).

23. Respondent stated in the discharge summary that the nuchal cord was unable to be reduced at the perineum but was slipped over the fetal body during the course of delivery and clamped thereafter (Ex. 5, p. 4; T. 142). Respondent also documented that the cord around the infant's neck was "so tight that I couldn't even get my finger between it and the neck once the head was delivered" (Ex. 24, p. 8; T. 143). If the cord was truly tight and was constricting blood vessels, clamping and cutting the cord at the perineum prior to the delivery of the baby's shoulders was indicated (T. 144).

24. Once it was determined that the baby's condition required immediate resuscitation, it was not appropriate for anyone but the Respondent to cut the cord so that the baby could be transferred immediately to the pediatrician (T. 146). No time should be wasted in circumstances where the baby needs oxygen, suctioning and resuscitation (T. 146). It was a deviation from the standard of care for Respondent to fail to clamp and cut the cord upon delivery of the infant's head (T. 146-147).

Patient A - 2003 Delivery

25. Patient A received prenatal care from Respondent in 2003.

26. Respondent and Patient A agreed that due to the fetal death of her baby in 2001, Patient A would be delivered by cesarean section after 38 weeks gestation on December 15, 2003 (T. 387-388; Ex. 8, p. 68).

27. The thirty-ninth week of gestation is significant because it is assumed that the fetal lungs will be mature and therefore the risk of the baby experiencing respiratory difficulties following delivery will be much lower (T. 388-389).

28. Respondent performed a non-stress test on Patient A on December 4, 2003 (Ex. 8, p. 217; T. 392).

29. A non-stress test is a fetal monitoring test which traces the fetal heart rate and contractions. The objective is to identify

accelerations of the fetal heart rate in relationship to movement of the baby which suggests that the fetus is not undergoing intrauterine stress and becoming hypoxic (T. 389).

30. A reactive non-stress test is a positive finding suggesting the fetus is not hypoxic. Reactivity is determined by an increase in the fetal heart rate of at least 15 beats per minute over the baseline within a 20 minute period on two occasions associated with fetal movement (T. 390).

31. Patient A had five reactive non-stress tests prior to the test performed on December 4, 2003 (T. 390; Ex. 8, p. 220-242).

32. There was no medical indication for a non-stress test on December 4, 2003, and it is likely that it was ordered to reassure Patient A as to her fetus's condition (T. 392). The non-stress test performed demonstrated average variability, with a random deceleration with accelerations to suggest that the test was reactive (T. 394). There was a deceleration which could be construed as a variable deceleration. The tracing itself is not good because there are breaks in the strip, possibly due to Patient A moving. It is preferred that the strip be continuous (T. 392-393). These findings, particularly the deceleration, suggested that Patient A required additional testing to determine fetal status (T. 394).

33. Given Patient A's loss in 2001, any suggestion of a health risk to her fetus would obviously raise her anxiety level. To assure Patient A of the fetus' condition, accepted standards of care would require further assessment of the fetus by further monitoring of the fetal heart rate in the hospital or by a biophysical profile (T. 394-395).

34. The biophysical profile provides more data points than a non-stress test as to fetal well-being, including amniotic fluid volume, breathing, tone and motion (T. 395). From this information fetal well-being can be assessed.

35. If Respondent suspected a late component to a deceleration, the standard of care would require either further monitoring in the hospital or a biophysical profile (T. 397). The non-stress test is a screening test and is not sufficiently accurate by itself to make a management decision (T. 397-398).

36. Respondent performed an abdominal ultrasound following the non-stress test but did not obtain the data points of a biophysical profile necessary to make a management decision (T. 399-400). Missing on the ultrasound report were the amniotic fluid volume, fetal breathing, fetal tone and the fetal motion. If Respondent determined that the amniotic fluid level was satisfactory, it would suggest that the likelihood of the fetus being hypoxic was not very

great (T. 400). There is no documentation of the amniotic fluid level in the medical record (T. 400).

37. Patient A was sent from Respondent's office to the hospital for delivery. During five hours of monitoring, there were some contractions noted on the fetal monitoring strip. There were no decelerations with the contractions, and the recorded fetal heart rate over five hours was reactive and reassuring (T. 401-402). It was a deviation from accepted standards of care for Respondent to deliver Patient A's baby without performing a biophysical profile or other monitoring (T. 405).

38. Respondent delivered Patient A by cesarean section on December 4, 2003 at 37 and 2/7 weeks (Ex. 9, p. 86; T. 402-403). The risk to the baby in delivering at that age would be that the fetal lungs may not be as mature as at an older gestational age with the risk of the baby suffering respiratory distress necessitating resuscitation (T. 403). Obstetricians cannot assume that at 37 and 2/7 weeks that the baby would not have respiratory distress following delivery (T. 403).

39. For an elective delivery prior to 39 weeks, the standard of care would be to determine fetal lung maturity by obtaining a specimen of amniotic fluid to analyze for substances which would determine fetal lung maturity (T. 404). There was no amniotic fluid

obtained to determine fetal lung maturity by Respondent (T. 404). Respondent's delivery of Patient A on December 4, 2003 by cesarean section without determining fetal lung maturity was a deviation from accepted standards of care (T. 405).

40. The abdominal ultrasound noted a grade III placenta (T. 408). A grade III placenta at 37 and 2/7 weeks would indicate a mature placenta and would be a variation of normal (T. 409). However, to determine whether the placenta was hypermature would require a pathological evaluation (T. 409).

41. Patient A's baby had Apgar scores of 7 and 9 at one and five minutes of life (Ex. 9a, p. 4; T. 409). These are acceptable scores.

42. Physical examination showed that the baby had retractions, intermittent grunting and tachypnea (Ex. 9a, p. 4). This would indicate difficulty with oxygen intake because the lungs were somewhat congested (T. 409-410). The baby was given oxygen for one day and closer observation (T. 410).

Patient B

43. Patient B was first seen by Respondent for prenatal care on January 30, 2003. This was her first pregnancy, and she had a history of deep vein thrombosis (Ex. 11, p. 9; T. 473).

44. On September 10, 2003, Patient B was at 40 and 1/7 weeks gestation, and Respondent noted that she was in early labor (Ex. 11, p. 10). Respondent sent her to the hospital for artificial rupture of her membranes (T. 474).

45. At 2:44 a.m. on September 11, 2003, Patient B was 10 cm dilated, 100% effaced and at 0 station (Ex. 12, p. 80; T. 475). At 3:34 a.m., Respondent instructed Patient B to start pushing (Ex. 11, p. 81; T. 475).

46. At 7:00 a.m. on September 11, 2003, Patient B was 10 cm dilated, 100% effaced and at +1 station. Respondent was made aware of these findings (Ex. 11, p. 104).

47. A note at 7:10 a.m. in the labor record indicates that Patient B was sitting up in bed and that Respondent was in to do a forceps attempt (Ex. 11, p. 82, 83; T. 478-479).

48. The delivery note written by the chief resident documented that Patient B had pushed for three hours and that the fetal head was in a transverse presentation or was asynclitic (Ex. 11, p. 101; T. 480).

49. The findings of transverse presentation and asyncliticism would suggest that patient B's pushing efforts were reasonably good in order for the bones to change their configuration (T. 481). As Patient B was attempting to push the fetus down, the fetus was

running into the pelvic bone and could not completely rotate (T. 481). The pressure of the head pushing against the pelvic bone caused the anatomical change in the fetal head. The transverse presentation and asyncliticism would raise concern of the compatibility of the pelvis with either the size or the position of the baby (T. 482). If Patient B had been satisfactorily pushing for a long period of time and had not made significant progress but had anatomical changes to the fetal head, the condition known as cephalopelvic disproportion would be considered (T. 482).

50. Respondent intended to use forceps to rotate the fetal head and then deliver the fetus, but he could not determine with sufficient certainty the anatomical landmarks of the fetal head in order to safely apply the forceps (T. 1244-1247). Respondent elected to use the vacuum extractor to bring the fetal head down to a position where he could determine the landmarks and apply Keilland forceps to rotate the baby and then Luikart-Simpson forceps to deliver the baby (T. 1247-1248). It was a deviation from accepted standards of care for Respondent to use the vacuum extractor when he could not determine the anatomical landmarks on the fetal head (T. 486-487, Ex. 29, p. 5).

Patient C

51. Patient C started prenatal care with Respondent on March 5, 2003. She had had a prior cesarean section for a breech presentation in 2000, delivering a 9 lbs, 7 oz baby (Ex. 13, p. 7; T. 552). The estimated date of confinement for the current pregnancy was August 24, 2003. The patient desired a vaginal birth (Ex. 13, p. 7; T. 552). A vaginal birth after cesarean section (VBAC) poses the risk of uterine rupture in the area of the previous cesarean section scar once the patient goes into labor (T. 552-553). Patient C was a candidate for VBAC delivery given that her prior scar was low in the uterus and transverse (T. 552-553).

52. On August 20, 2003, the gestational age of Patient C's pregnancy was 39 and 3/7 weeks. The progress of the labor had been normal to that point (Ex. 13, p. 7; T. 554).

53. At the August 20, 2003 office visit, it was noted, among other things, that Patient C had a five pound weight gain from her previous visit, and some irregular contractions (Ex. 13, p. 7). Her cervix was 2 to 3 cm dilated, 90% effaced, and the fetus was at -3 station (Ex. 13, p. 7; T. 554). Given these clinical findings, the standard of care would be expectant management, as there was a strong likelihood she would go into more spontaneous labor within the next week (T. 555).

54. Respondent admitted Patient C to the hospital the following morning on August 21, 2003 (Ex. 14, p. 49; T. 555-556). Patient C was 1 cm dilated, 90% effaced, at -3 station, and she was not contracting (Ex. 14, p. 49; T. 556).

55. Respondent artificially ruptured Patient C's membranes at 8:38 a.m. without medical indication (T. 556).

56. The risks to Patient C and/or her fetus of rupturing membranes at -3 station include umbilical cord prolapse due to the high position of the head (T. 557).

57. Further, rupturing membranes with the cervix at 1 cm dilated when Patient C was not having contractions, created the risk that the labor would be prolonged as the cervix was only borderline favorable (T. 557). In prolonging the time until delivery, there is an increased risk of infection to the patient (T. 557).

58. A reasonably prudent physician would not have ruptured Patient C's membranes at that time (T. 558).

59. At 12:20 p.m. on August 21, 2003, an epidural was started for Patient C to provide pain relief (Ex. 14, p. 32; T. 560). At 2:25 p.m., Patient C requested that her epidural be topped off (Ex. 14, p. 36; T. 560).

60. A top off would suggest that the effectiveness of the epidural was diminishing; Anesthesia was called to provide more

medication in order to make the epidural more effective in pain relief (T. 560-561).

61. At 2:35 p.m., a resident's note indicated that the cervix was anterior lip, 100% effaced, 0 station, and that the epidural would be topped off (Ex. 14, p. 52; T. 561-562). A normal spontaneous vaginal delivery was anticipated (Ex. 14, p. 52; T. 562). At 3:09 p.m., Patient C was 10 cm dilated, 100% effaced at +1 station (Ex. 14, p. 37; T. 561).

62. At 4:00 p.m., Respondent's progress note indicated that Patient C had been pushing for more than 30 minutes with descent of the fetal head (Ex. 14, p. 52; T. 562). The fetal head was left occiput posterior (Ex. 14, p. 52). Respondent described Patient C as in agony and begging for relief (Ex. 14, p. 52). He noted that as a primip pelvis, Patient C had little chance for spontaneous rotation. Respondent offered Patient C the options of continuing to push, a repeat cesarean section, or forceps rotation and delivery. According to the Respondent's note, Patient C selected a forceps rotation and delivery (Ex. 14, p. 52, T. 562-563).

63. Patient C's pushing efforts were effective in causing some progress in terms of the fetal head moving down into the pelvis (T. 563).

64. Patient C testified that if she elected to continue to push, she would not receive any more epidural during the time that she was pushing (Ex. 28, pp. 546-548). The accepted standard of care would have been for Respondent to give Patient C more epidural and allow her to push (T. 565-569). The only limitation with respect to the epidural is that the epidural not be too high so that there would be limitations on Patient C's ability to push (T. 565-566).

65. The majority of primagravida patients are able to rotate the fetus spontaneously with adequate pushing (T. 566-577).

66. There were no fetal indications for forceps delivery (T. 567).

67. Keilland forceps were applied to rotate the fetus to an occiput anterior position (Ex. 14, p. 53; T. 567-568). Luikart-Simpson forceps were then applied, and the delivery was accomplished (T. 568). Bilateral sulcus tears to the vaginal walls were sustained during the forceps delivery (Ex. 14, p. 53; T. 568). The bilateral sulcus tears to the vaginal walls were caused by the forceps (T. 569). When forceps are applied to the fetal head they occupy more space in the vagina than would a vacuum which is placed on top of the fetal head (T. 569). The forceps distend the vaginal walls as the fetal head is brought down, and there is a tendency for tissue to be injured in this process (T. 569).

68. On Patient C's six-week check-up following delivery, granulation tissue was noted on the right and left vaginal walls (Ex. 13, p. 33; T. 570). Granulation tissue indicate that the sulcus tears had not completely healed (T. 570-571). On December 22, 2003, granulation tissue was still noted in the vagina, and Patient C continued to complain of some discomfort with sexual intercourse due to the granulation tissue (T. 571).

Patient D

69. On October 21, 2005 Patient D was seen at Promptcare in Syracuse, New York after a positive home pregnancy test (Ex. 15, p. 75; T. 622). Patient D gave a history of the last menstrual period in the beginning of June (Ex. 15, p. 75; T. 622-623). Patient D was noted to have a history of irregular periods.

70. The concept "last normal menstrual period" in relation to "last menstrual period" can be significant regarding the dating of a pregnancy (T. 623). Patients may confuse bleeding for a menstrual period, and by indicating a last normal menstrual period, it suggests bleeding which Patient D considered normal menstrual bleeding (T. 623).

71. With irregular bleeding, it may be difficult to date the pregnancy by an episode of bleeding which is not a normal menstrual period (T. 623).

72. Promptcare estimated the gestational age of Patient D's fetus as 19 and one half weeks at the time of her October 21, 2005 visit (Ex. 15, p. 76; T. 624).

73. Patient D was seen in Respondent's office on October 31, 2005 at which time a history was taken by staff that included a last menstrual period that was recorded as: "8/end/05?" (Ex. 15, p. 33; T. 624). This would indicate that whoever took the history was not certain that this represented the patient's last menstrual period (T. 624). It is very difficult to date a pregnancy based on a last menstrual period if the patient does not remember exactly when the menstrual period occurred (T. 625).

74. The office note documents an intention to get a human chorionic gonadotropin (HCG) level. The level of HCG in the patient's blood rises as the pregnancy progresses and develops (T. 626).

75. The office note refers to obtaining Patient D's progesterone level (Ex. 15, p. 33; T. 626). Progesterone is a hormone initially produced by the ovary causing changes in the uterus which permits it to support an early pregnancy (T. 626). Patient D's progesterone level obtained on October 31, 2005 was 150.25 (Ex. 15, p. 53). In the reference range provided on the lab report, a progesterone level of 150 in a pregnant female corresponds to a third

trimester pregnancy (Ex. 15, p. 54; T. 628). The HCG value of 4496.7 when taken with the progesterone level is consistent with a second or third trimester pregnancy (T. 629).

76. The HCG and progesterone values were repeated on a blood draw of November 4, 2005 (Ex. 15, p. 54). The repeat progesterone value was 156.15 and the HCG value was 4265.5. These numbers do not represent a significant change in either the progesterone or the HCG values and would be consistent with a third trimester pregnancy (T. 630).

77. Respondent's note of November 4, 2005 stated, among other things, that Patient D had a drop in the HCG level, and that he diagnosed Patient D as having an eight to nine week pregnancy by last menstrual period, consistent with a non-viable, intrauterine pregnancy, given the drop in the HCG level (Ex. 15, p. 33).

78. Respondent's progress note further indicates the need for a sonogram. A sonogram would be valuable in attempting to date the pregnancy (T. 632). The sonogram would also be valuable in the interpretation of the HCG level with the serum progesterone level (T. 632).

79. Respondent's diagnosis of an eight to nine week, non-viable pregnancy was based on a questioned menstrual period history (T. 633). The menstrual period history is non-specific and unclear, and

therefore could not be used to establish the age of the pregnancy (T. 633).

80. Further, the HCG level cannot be interpreted alone and must be considered in conjunction with the serum progesterone level which placed the pregnancy in the third trimester (T. 633-634).

81. A sonogram was performed on November 7, 2005 using a vaginal probe (Ex. 15, p. 43). An abdominal ultrasound uses an abdominal transducer which is placed across the patient's abdomen and which views the uterus through the abdomen (T. 634). A transvaginal ultrasound utilizes a vaginal probe which is placed into the patient's vagina and has the advantage of getting closer to the uterus and other pelvic structures (T. 634-635).

82. A transvaginal ultrasound was obtained of Patient D, and the only measurement reported was cervical length (Ex. 15, p. 43). However, in a first trimester pregnancy, the transvaginal ultrasound should be able to image the uterus and its contents, the cervix and the ovaries (T. 635-636). The transvaginal ultrasound should permit the measurement of the length and width of the uterus in centimeters as well as visualizing the cavity and the structures in the uterine cavity consistent with pregnancy or the absence of such structures (T. 636). This would provide an indication as to the age of the pregnancy (T.636). It is considered a more accurate means of

determining the gestational age than the last menstrual period (T. 636). Even in an obese patient, the transvaginal ultrasound should be capable of visualizing the uterine cavity if the uterus is in the pelvis (T. 637).

83. Given the absence of uterine measurement in the sonogram report, a reasonably prudent obstetrician would consider the exam incomplete and would not use it to make management decisions regarding the patient (T. 637-638). More information about the pregnancy from another source was necessary. Another potential source of information for the pregnancy would be an abdominal ultrasound (T. 638). Respondent's failure to order an abdominal ultrasound or some further evaluation of Patient D for purposes of dating the pregnancy was a gross deviation from accepted standards of care (T. 639). Respondent made management decisions including the administration of Methotrexate and performing a D&C on Patient D without obtaining further information regarding the pregnancy (T. 639-640).

84. On November 7, 2005, the same date as the ultrasound, a third HCG level of 4793.9 was obtained as well as a third progesterone level of 153.35 (Ex. 15, p. 55). The HCG level was essentially in the same range as the earlier levels. The serum progesterone level remained in the third trimester range (T. 640).

85. On November 8, 2005, Patient D reported some pelvic pressure, and described movement felt in the pelvic region, as well as pelvic tightness which had started the previous evening. She stated that her bowels and kidneys were normal (Ex. 15, p. 34).

86. This sensation of pelvic pressure could be consistent with a number of conditions including constipation and intestinal gas, although Patient D reported her bowels and kidneys to be normal (T. 642). It could also be consistent with a fetus moving, if the obstetrical patient was in the second or third trimester (T. 642-643).

87. On November 8, 2005, Respondent ordered Patient D to be given 125mg of Methotrexate (Ex. 15, p. 34). In obstetrics, Methotrexate has been used to terminate pregnancies in the first trimester (T. 643). The use of Methotrexate involves risks of liver and blood damage (T. 643-644).

88. Respondent's documented indication for the use of Methotrexate was a missed abortion (Ex. 15, p. 34). Respondent's diagnosis of a missed abortion is unsupported by any clinical evidence as to the location of the pregnancy, (T. 644).

89. Methotrexate requires evaluation of the patient's blood count, platelet count, liver function and renal function prior to its administration to determine whether there is any underlying pathology

which would increase the risks of using Methotrexate; there were no such studies performed in this instance (T. 644-645). The failure to do so was a deviation from accepted standards of care (T. 645).

90. The use of Methotrexate did not terminate Patient D's pregnancy (T. 645). The long term effects of the use of this drug on Patient D's baby are unknown (T. 646-647). Following the administration of Methotrexate, Respondent again ordered a fourth HCG level (4627.5) and a fourth progesterone level (211.57) on November 14, 2005 (Ex. 15, p. 56). The failure of the quantative HCG to go down after the use of Methotrexate and the rise of the serum progesterone level would cause a reasonable physician to question the pregnancy (T. 649-650). A serum progesterone level as high as 211 is unusual, and a reasonably prudent obstetrician who did not understand its significance would consult with a perinatologist or colleague in these circumstances (T. 650).

91. When the Methotrexate did not expel Patient D's pregnancy, Respondent performed a dilation and curettage (hereinafter "D&C") on November 23, 2005 at Crouse Hospital (Ex. 16, p. 31; T. 650). The operative note for the D&C indicated that Respondent sounded the uterus to 11 cm (Ex. 16, p. 49). This would ordinarily measure from the cervix to the top of the uterus (T. 651). Respondent's finding

that the uterus measured 11 cm is inconsistent with a pregnancy of more than 34 weeks (T. 652-653).

92. Performing a D&C in circumstances of a pregnancy which is more than 34 weeks creates risks of rupturing the membranes, injuring the fetus, perforating the uterus and causing extensive hemorrhage which can be potentially life threatening to the mother (T. 653). Performing a D&C at this advanced gestational age would create a significant risk to both the mother and the baby.

93. Given that Respondent did not have a reliable diagnosis of the age of the pregnancy, there was no indication to use Methotrexate and no indication to do a D&C (T. 653-654). Respondent's assumption that Patient D had a missed abortion and was 8 to 10 weeks pregnant was not based on adequate information since he was unable to visualize the uterus or to palpate it (T. 654). Respondent's treatment with Methotrexate and his performance of a D&C on Patient D were in each instance gross deviations from accepted standards of care (T. 654).

94. The pathology report from the D&C report indicated that there was no pregnancy tissue identified (T. 654-655; Ex. 16, p. 47). Typically in an eight to ten week missed abortion, the pathology would show chorionic villi (T. 655).

95. Following the D&C, Patient D was seen in Respondent's office on December 7, 2005 with complaints of lower pelvic pain (Ex. 16, p. 36). Respondent took a history from Patient D that she ran out of oral contraceptives in May 2005 (Ex. 16, p. 36; T. 656). This history did not previously appear in Respondent's notes (T. 656). The history of not using oral contraceptives after May 2005, would be consistent with the patient's inability to provide a date for the last menstrual period. It would further suggest that the date provided was not accurate for purposes of calculating gestational age (T. 656). On December 7, 2005 Patient D was sent to the emergency department of Crouse Hospital from Respondent's office with concerns that she may have an ectopic pregnancy (T. 657). An abdominal ultrasound study done while Patient D was in the emergency department demonstrated a 38 and one-half week, full-term pregnancy and a fetal heart rate of 140 beats per minute (T. 657). Patient D's body size did not impair the abdominal ultrasound results (T. 658).

96. Patient D delivered a 7lbs, 15oz, male infant on December 7, 2005 with Apgar scores of 9 and 9 at both one minute and five minutes (Ex. 16, p. 62; T. 658). Following the delivery Respondent documented that Patient D's body size was a major factor in missing the diagnosis of a third trimester pregnancy (Ex. 16, p. 63; T. 659). While Patient D's weight made her evaluation much more difficult,

there were sufficient data points throughout the care that should have led Respondent to do additional testing and allowed him to correctly date the pregnancy (T. 659-660).

97. The four HCG values had to be explained or understood by Respondent in the context of the elevated progesterone values (T. 661). Respondent's failure to adequately assess the serum progesterone levels in the circumstances of Patient D's care was a deviation from accepted standards of care (T. 661). Respondent's failure to accurately diagnose Patient D's third trimester pregnancy was a gross deviation from accepted standards of care (T. 661-662).

Patient E

98. Patient E was seen in the emergency room at St. Joseph's Hospital on June 7, 2004 with complaints of vaginal bleeding on bathroom tissue (Ex. 18a, p. 7; T. 756). Patient E was then approximately 17 weeks pregnant (Ex. 181, p. 7; T. 756). Bleeding at 17 weeks, if coming from the uterus and associated with the pregnancy, would be diagnosed as a second trimester threatened abortion (T. 757).

99. On examination a scant amount of blood was found on the vaginal wall suggesting bleeding from Patient E's uterus (T. 757). If the bleeding continued, there was a risk that the pregnancy could ultimately be lost (T. 757-758).

100. The management of a patient in this condition is observation with instructions that the patient be less active and avoid sexual activity (T. 758).

101. On June 9, 2004, Patient E was examined in Respondent's office for the first time after having terminated her prenatal care with the physician who had been following her pregnancy (Ex. 18, p. 3; T. 760). Respondent was aware that Patient E had been treated at St. Joseph's Hospital Emergency Department and sent home after having been advised that there was nothing that could be done because the pregnancy was less than 24 weeks (Ex. 18, p. 3; T. 760).

102. When a pregnancy is less than 24 weeks and the baby delivers alive, the baby is too immature to survive. After 24 weeks with vigorous treatment, the potential exists for the baby's survival (T. 761). There is no data to support aggressive management of a patient that is threatening to lose a pregnancy in circumstances in which she is bleeding from the uterus and having cramps prior to 24 weeks (T. 761). A sonogram performed on June 14, 2004 described, among other things, a sub-chorionic bleed (Ex. 18, p. 3). A subchorionic bleed would indicate that vessels under the chorion, which is part of the placental membranes, are bleeding (T. 762). This bleeding and Patient E's complaints of discomfort indicates that

the bleeding is causing an irritation and contractions of the uterine muscle (T. 762).

103. The sonogram confirmed that Patient E's bleeding was coming from within the uterus, creating the risk that the pregnancy would ultimately be expelled because the uterus was contracting as a result of the bleeding (T. 763). Irritated by continued bleeding, the uterus will contract causing the cervix to dilate, the membranes to rupture and the pregnancy to deliver at an age too early for the baby to survive (T. 763-764). If the bleeding stops and the contractions cease, the pregnancy can conceivably continue (T. 764).

104. Respondent's treatment plan was to admit Patient E to the hospital to "calm the uterus and support the pregnancy" (Ex. 18, p. 3; T. 765). The standard of care for treating this condition would be to observe the patient and give her IV fluids, and it would have been acceptable to admit her to the hospital for these purposes (T. 765).

105. Patient E had a threatened second trimester spontaneous abortion (T. 766-767).

106. Respondent has stated that Patient E did not have a threatened second trimester spontaneous abortion but was in preterm labor (T. 766-767; Ex. 27, pp. 44-47). Preterm labor is contractions in pregnancy after 20 weeks that show signs of cervical dilatation

and effacement; however, Patient E's pregnancy was prior to 20 weeks (T. 767).

107. Respondent's admission note reported that Patient E continued to have contractions as a result of the bleeding and that he started her on magnesium sulfate (Ex. 19, p. 97; T. 767-768).

108. Magnesium sulfate is a compound which can relax smooth muscle and has been used to treat preterm labor by attempting to relax the uterus and stop contractions (T. 768). Patient E was continued on magnesium sulfate during the course of her hospital admission. There were no indications for using magnesium sulfate for treating uterine contractions due to a subchorionic hemorrhage in the second trimester; Respondent's use of magnesium sulfate in his treatment of Patient E was a deviation from accepted standards of care (T. 769-770).

109. There are risks to the patient in using magnesium sulfate to the extent ordered by Respondent in Patient E's care. Magnesium sulfate can block the muscles and lead to respiratory depression and ultimately death if it is not closely monitored (T. 770). Patient E experienced side effects from the use of magnesium sulfate including slurred speech for a few days and an inability to focus for several days (Ex. K, p.1). Respondent did monitor the use of magnesium sulfate during the course of the admission (T. 770-771).

110. Despite the use of magnesium sulfate, Patient E continued to have contractions and bleeding throughout the course of both admissions (T. 771).

111. On June 10, 2004, Respondent reduced the magnesium sulfate rate to 1.5gr/hour and noted a plan to discharge Patient E the following day (Ex. 19, p. 102; T. 772). The magnesium sulfate was turned off at one point; however, Patient E began contracting again (Ex. 19, p. 104; T. 772). This would indicate the uterus remained irritable, probably due to the presence of blood (T. 772).

112. On June 14, 2004, Respondent noted that a sonogram had reported that the patient's cervix measuring only 1.75 cm (Ex. 19, p. 114). The cervix initially measured 4.4 cm and was now considerably shorter as a result of the uterine contractions (T. 773).

113. As the cervix becomes shorter it will ultimately start to dilate (T. 773). When the cervix dilates, there is a high possibility that the membranes will rupture and the pregnancy will be expelled (T. 773-774). On June 14, 2004, Respondent assessed the pregnancy as 18 3/7 weeks with contractions that had caused early "cervical incompetency" (Ex. 19, p. 114; T. 774). Cervical incompetency or cervical insufficiency describes an inherent abnormality of the cervix in which it dilates in the absence of contractions (T. 774).

114. Patient E's cervix was dilating due to her contractions and not an abnormality (T. 774-775). The natural state of a cervix is to dilate in response to contractions (T. 775). A cervical cerclage is a procedure by which sutures are placed in the cervix in order to keep the cervix from dilating (T. 775). The sutures essentially keep the cervix closed (T. 775). Dilatation of the cervix by contraction is not treated with a cerclage (T. 775).

115. Cerclage is appropriately indicated where there is a diagnosis of cervical insufficiency in circumstances where the cervix dilates in the absence of contractions prior to infant viability (T. 775). Patient E did not have cervical incompetency or cervical insufficiency which could properly be treated by cerclage (T. 776).

116. Respondent placed a cervical cerclage in Patient E's cervix on June 16, 2004 (Ex. 19, p. 157; T. 776).

117. Respondent's placement of the cervical cerclage was a gross deviation from accepted standards of care (T. 778). It was inappropriate to put a cerclage in a patient having contractions and bleeding (T. 779).

118. The risks of placing a cerclage in these circumstances include causing infection which may precipitate delivery, injure the bladder, and injure the cervix (T. 779).

119. The cerclage could stimulate the uterus to contract just from the manipulation of the cervix in placing the stitches (T. 779).

120. Patient E was discharged on June 20, 2004, but was readmitted to the hospital the same day (Ex. 20, p. 103). Patient E had been sent home on oral tocolytics and then had a recurrence of bleeding and intense contractions. Upon readmission, Patient E was restarted on magnesium sulfate (Ex. 20, p. 103; T. 780).

121. Even with extended use of tocolytics, Patient E had continued bleeding and contractions with cervical dilation (T. 781). There was further risk that with a stitch in the cervix and the uterus bleeding, it would be difficult to determine how much blood Patient E was actually losing and the possible accumulation of blood in the uterus would increase Patient E's health risks (T. 781-782). Patient E continued to have bleeding and contractions during the course of the second admission (Ex. 20, p. 4). Patient E also had intense uterine contractions which required what Respondent described as "high doses of magnesium sulfate, upwards of 3+ grams per hour" (Ex. 20, p. 4).

122. Respondent had an ultrasound performed on Patient E on July 7, 2004 (Ex. 20, p. 155; T. 782). The amniotic fluid index was identified as 0 (Ex. 20, p. 155; T. 782-783).

123. Once the amniotic fluid had leaked out of the gestational sac, it was very unlikely that Patient E's baby would deliver normally because amniotic fluid is necessary for lung maturation (T. 783).

124. Given the amniotic fluid index of 0, it was not appropriate for Respondent leave the cerclage in place (T. 783-784). While cerclages are continued with ruptured membranes, they are not used in circumstances of abruptions or in situations with clinical backgrounds similar to Patient E's (T. 783). There was virtually no possibility of Patient E's pregnancy coming to a successful outcome after the loss amniotic fluid (T. 783-784). Further, there was a risk of infection that could potentially compromise Patient E's future fertility. If the bleeding resulted in significant anemia, it could threaten Patient E's life (T. 784).

125. On July 9, 2004, Patient E started to have significant contractions, and Respondent, noting that survivability at only 22 weeks with no amniotic fluid was essentially 0%, removed the cerclage (Ex. 20, p. 163).

126. Respondent's failure to remove the cerclage two days earlier on July 7, 2004 when the amniotic fluid measured 0 was a gross deviation from accepted standards of care (T. 788-789).

127. Patient E delivered a stillborn baby on July 10, 2004 (Ex. 20, p. 165).

128. Regardless of the risks Respondent described to Patient E in commencing therapy, Respondent misled Patient E to believe that there was a treatment for her condition and thus exposed her to the risks of medication and the risks of surgical procedures which may have contributed to the loss of the pregnancy (T. 789-790). Respondent told Patient E that the magnesium sulfate would slow the contractions and that she would be discharged the first weekend (Ex. K, p. 2). Respondent told Patient E that everything would be fine and that it was rare that he was trying to save her pregnancy (Ex. K, p. 2)

129. Respondent had an ethical obligation to advise Patient E that treatment to preserve her pregnancy was beyond his capability despite any desire by Patient E to submit to such treatment (T. 790).

130. At the time of Patient E's admission to the hospital on June 9, 2004, her hematocrit was 34 (Ex. 19, p. 135). A low normal hematocrit is 36 (T. 791). Patient E's hematocrit on June 21, 2004 at the time of her readmission to the hospital was 26.4 (Ex. 20, p. 173). It was obvious that Patient E had experienced significant blood loss during her hospitalization. On July 9, 2004, Patient E's

hematocrit measured 22 and her hemoglobin was 7.8 (Ex. 20, p. 173; T. 791).

131. On July 10, 2004, the date of discharge, Patient E's hematocrit was 17.2 and hemoglobin was 6.1 (Ex. 20, p. 173; T. 792). At these values, Patient E was at risk of shock and death if she sustained any serious bleeding (T. 792).

132. The accepted standard of care would have been for Respondent to advise Patient E that her hematocrit was low before he discharged her (T. 792-793). A determination would then have to be made as to whether Patient E could function with a hematocrit that low in terms of her pulse and blood pressure (T. 792-793). A blood transfusion may have been indicated if Patient E could not function appropriately.

133. Given the fact that Patient E had a hematocrit of 22 on July 9, 2004, Respondent should have reviewed the hematocrit on the day of discharge, July 10, 2004 (T. 793-794).

134. Patient E's chart at Respondent's office indicates that on July 16, 2007, Patient E was advised of her low hemoglobin and hematocrit values as of July 10, 2004, and that she was given a prescription for ferrous sulfate, an iron preparation (Ex. 18, p. 30; T. 794-795). Ferrous sulfate would help the body rebuild red blood cells (T. 795).

135. There was no documented treatment of Patient E's low hemoglobin and hematocrit levels prior to July 16, 2004. Respondent's failure to institute treatment prior to July 16, 2004 was a deviation from accepted standards of care (T. 795).

136. The discharge summary for Patient E's admission to the hospital during the period from June 20, 2004 to July 10, 2004 references Patient E's hematocrit level and her treatment with an iron preparation (Ex. 20, p. 5).

137. Respondent's discharge summary, dictated on August 6, 2004, states the following, among other things:

> She [Patient E] was sent home within 4-6 hours postpartum once stable. Her hemoglobin at the time of discharge was 6.1, which was artifactually low from 7.8 earlier that shift. This was markedly anemic given her level of bleeding. She was started on iron therapy and was otherwise stable. She exhibited no further signs of bleeding prior to discharge. (Exhibit 20, p. 5).

The discharge summary implies that the Patient E's low hematocrit level was recognized and treated in the hospital.

138. The discharge summary does not accurately reflect Patient E's treatment in the hospital. It was inappropriate for Respondent to imply that Patient E received iron therapy in the hospital (T. 797).

Patient F

139. Patient F was examined by Respondent on April 17, 2000 for complaints of nausea, gas, and discomfort on the right side of the abdomen and pelvic area (Ex. 21, p. 47; T. 846). Patient F was 52 years old and weighed 237 pounds (Ex. 21, p. 47).

140. Patient F's past surgical history included gallbladder surgery, stomach stapling, appendectomy and a right salpingo oophorectomy (Ex. 22, p. 7; T. 846). Respondent diagnosed Patient F's complaints of abdominal and pelvic pain as related to adhesional disease following her prior surgeries (T. 847).

141. Adhesions are scarring bands that form following surgery and adhere to organs and restrict their movement (T. 848). Any time there is interference with mobility of structures, and structures become distended, the nerve endings can become irritated causing the patient to experience discomfort (T. 848-849).

142. Following her evaluation Patient F underwent a pelvic ultrasound which illustrated no adnexal masses, a normal left ovary, and bowel filling in the right adnexal region (Ex. 21, p. 19; T. 849).

143. The ultrasound findings suggested the presence of bowel in Patient F's right lower quadrant in the area where Patient F complained of pain (T. 849). This indicated that the bowel may have

been adherent in the right lower quadrant so that as food passed through the bowel, the bowel was stretched and was unable to move freely (T. 849). This would cause Patient F to have pain (T. 849-850).

144. Patient F's adhesions were related principally to bowel adhesions in the right lower quadrant which is a general surgery issue rather than a gynecological issue (T. 820). It is unlikely that Patient F's condition was related to adhesions originating in the pelvic structures themselves (T. 850).

145. Respondent scheduled an open laparoscopic procedure to explore for adhesions and to correct them on July 28, 2000 (Ex. 22, p. 2).

146. Respondent performed the open laparoscopic procedure (T. 851). By this method, the surgeon makes incisions in the abdomen and dissects down to the peritoneal tissue so that the trocar can be inserted under direct visualization rather than inserting the trocar blindly into the peritoneal cavity (T. 851).

147. The laparoscopic procedure presents risks of bleeding, infection and damage to structures where the surgeon is operating (T. 852). The surgeon relies on the mobility of the bowel so that it can be moved during the procedure to prevent injury (T. 852).

148. Patient F was at greater risk for bowel injury than the usual laparoscopic procedure risk (T. 852-853). Patient F had had

four prior abdominal procedures and had known adhesional disease based on the findings of one of the prior surgeries (T. 853).

149. In addition to Patient F's obesity and past surgical history, her prior medical history included hypertension, diabetes, coronary artery disease, arthritis, high cholesterol, degenerative joint disease and gastroesophageal reflux disease (Ex. 22, p. 7; T. 854). An arteriogram showed some disease in her coronary arteries, thus creating an anesthesia concern (T. 854-855). Patient F was a higher risk surgical patient (T. 1803).

150. Given the concern for the risk of bowel injury, consultation with a general surgeon prior to surgery was indicated to insure that a general surgeon was available if that the bowel was injured during the laparoscopic procedure (T. 853-854).

151. Respondent failed to consult with a general surgeon prior to Patient F's laparoscopic procedure (T. 855). Respondent's failure to consult with a general surgeon was a deviation from accepted standards of care and a deviation from the care that a reasonably prudent gynecologist would exercise under such circumstances (T. 855).

152. The surgery was performed on Friday, July 28, 2000 (T. 857). On entering the peritoneal cavity, Respondent discovered a loop of small bowel just under the peritoneum that was adherent and which had been injured by the instruments he was using (Ex. 22, p. 2).

Respondent described the injury as a small rent to the serosa of the small bowel (T. 858).

153. The serosa is the surface layer of the small intestine (T. 858). Respondent repaired the injury with sutures, closing the wound in a double layer (Ex. 22, pp. 2,4; T. 858-859). Respondent could reasonably expect that there would be further manipulation of the bowel during the course of the surgery (T. 859). The bowel is exposed to risk of injury in any procedure involving adhesions which makes the bowel adhere to other structures within the abdomen such as the pelvic area, the uterus or other bowel loops (T. 859-860). In attempting to break down those adhesions, there is a risk of injury to the bowel (T. 859-860).

154. Respondent did significant lysis of adhesions to areas on the right side of the pelvis where the bowel was adherent (Ex. 22, p. 4; T. 860).

155. During the course of the laparoscopic procedure, Respondent perforated Patient F's uterus with a Kroner (Ex. 22, p. 2; T. 862-863).

156. Respondent's discharge instructions to Patient F were to remain NPO overnight with clear liquids for the next 36 hours, to take her temperature the next three days, three times a day, and to report any fevers (T. 864-865; Ex. 22, p. 5).

157. On the day following surgery, Patient F contacted

Respondent's answering service, after which Respondent returned the phone call and spoke to Patient F's husband (T. 866-867; Ex. 28, p. 459-461). Patient F's husband reported to Respondent that Patient F had a fever, and that Patient F's right side was bothering her (T. 867; Ex. 28, p. 459-461). Patient F's temperature was 101°(Ex. 28, p. 469).

158. With complaints of fever on the first post-operative day after the lysis of adhesions and of pain on the right side, the same side where there had been adherent bowel, Respondent should have advised Patient F to go to the emergency department to be examined (T. 867-868).

159. Patient F's complaints could have been consistent with a number of conditions, including a bowel injury causing an inflammatory reaction (T. 868). Her post-operative fever could be related to dehydration. However, when the fever is related to abdominal pain, there was a concern that there was a surgical injury with an inflammatory reaction causing the fever (T. 868-869).

160. Respondent indicated that when patients call with complaints such as those related by Patient F's husband, he commonly orders Milk of Magnesia to treat the patient for a possible ileus (Ex. 31, p. 500; T. 1549-1550).

161. An ileus is an interruption in the motility of the bowel associated with distention (T. 869). An interruption could be caused

by the surgical procedure itself, an obstruction of the bowel, or the medications being used (T. 869). In a patient with a bowel injury, an ileus would cause distention which could cause risks to the injury site (T. 869-870). A reasonably prudent physician would have directed Patient F to either be examined by the Respondent or in the emergency department at that time (T. 870). Respondent failed to direct Patient F to the emergency department or to present herself for examination by him; he recommended Milk of Magnesia (Ex. 28, p. 461).

162. Patient F was admitted to the hospital the following day on July 30, 2000 after her pain worsened. Patient F was noted to have had pain and shortness of breath since Saturday with nausea, vomiting, no bowel movements and poor appetite (Ex. 23, p. 150; T. 871). She was known to have a positive fever of 99.6 at home.

163. A resident's impression was that the following conditions should be ruled out: pulmonary embolism versus bowel perforation versus ileus (Ex. 23, p. 153; T. 871). A pulmonary embolism was a concern because of Patient F's complaint of shortness of breath. It was ruled out initially during her hospitalization (T. 871-872).

164. Patient F was very sick at the time of her admission. She had lysis of the adhesions two days earlier with a bowel injury and the bowel was now significantly distended (T. 874). She also had significant tachycardia. Her diabetes was out of control. Patient F

was at risk of losing her life; immediate surgical and medical consultations were indicated (T. 874).

165. Respondent did not obtain a medical consultation until August 1, 2000, and a surgical consultation was only obtained after the medical consultant recommended one (Ex. 23, p. 187; T. 874-875).

166. Patients that have had laparoscopic surgery can die quickly due to acute peritonitis from the bowel injury. Respondent's failure to obtain a surgical consultation prior to August 1, 2000 was a deviation from accepted standards of care (T. 875-876).

167. Patient F was taken for a laparotomy and small bowel resection and reanastomosis on August 2, 2000 (Ex. 23, p. 326; T. 876). A perforation was found in the ileum of the small bowel (T. 876). Patient F had an abscess which placed her at risk for septic shock and death (T. 876- 877).

CONCLUSIONS OF LAW

Respondent is charged with twenty 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 the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence and incompetence.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding. Id.

Gross Negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent a significant or

serious deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

The Department presented testimony by Robert Tatelbaum, M.D. Dr. Tatelbaum has been board-certified in OB/GYN since 1975. Over a period of approximately twenty-five years, he has been involved each year in one hundred deliveries on average and performed between thirty and fifty GYN surgeries. At present, Dr. Tatelbaum is the chief of the OB/GYN Department at Rochester General Hospital and an Associate Professor of Obstetrics and Gynecology at the University of Rochester School of Medicine and Dentistry. Dr. Tatelbaum had no stake in the outcome of this case and testified in an honest, direct and forthright manner. The Hearing Committee gave great weight to Dr. Tatelbaum's testimony. The Department also presented the transcribed prior testimony of David Brittain, M.D., and of Patient F's spouse which the Hearing Committee found to be credible.

Respondent presented the transcribed prior testimony of Steven Burkhart, M.D., as an expert witness on his behalf regarding the care provided to Patients A, B, C and F. Dr. Burkhart is board certified in OB/GYN and has practiced obstetrics and gynecology since 1986. Since then he has averaged between one hundred and one hundred seventy-five deliveries each year. Dr. Burkhart is a Physician and Managing Partner at Genesee Valley Obstetrics and Gynecology, P.C. in Rochester, New York. Dr. Burkhart had no stake in the outcome of this case, and the Hearing Committee also gave his testimony great weight.

Respondent presented the testimony of Ronald Stahl, M.D. as an expert witness in relation to Patients D, E and F. The Hearing Committee unanimously concluded that Dr. Stahl's expertise did not rise to the level of either Dr. Tatelbaum or Dr. Burkhart and accorded his testimony less weight. Respondent also presented the testimony of a labor and delivery nurse, Frances Campbell and a nurse practitioner, Teresa Monnett. The Hearing Committee found that the testimony of these two witnesses as well as the transcribed testimony of Patients A, B and C to be generally credible.

Although Respondent was represented by counsel, he chose to offer the opening and closing statements and to cross-examine the Department's expert. He also testified regarding his care of the six patients. Respondent clearly has a stake in the outcome of these proceedings. Although he appeared sincere, knowledgeable and dedicated to his profession, several aspects of his testimony were troubling. Respondent demonstrated a capacity to perform prohibited actions in that he admitted to using forceps on multiple occasions in a hospital during a period when the hospital had suspended and/or limited his privileges to do so. In addition, the evidence established that Respondent attempted to cover up his failure to recognize and treat Patient E's low hematocrit level by writing a discharge summary which implied that Patient E received iron therapy in the hospital.

Patient A - 2001 Delivery

Respondent ruptured Patient A's membranes when her cervix was one to two centimeters dilated, fifty percent effaced and the fetal head was at minus three station. Respondent contended that the medical indications for rupturing the membranes were that Patient A was in protracted latent phase labor and her cervix had changed (T. 922). Artificially rupturing the patient's membranes, however, exposed the patient to risks including the possibility of umbilical cord prolapse, and no medical justification existed for creating such a risk. The Hearing Committee concurred with Dr. Tatelbaum's opinion that a reasonably prudent physician would not have ruptured the patient's membranes under the circumstances.

Patient A was given Pitocin because her labor was not effective in causing the cervix to dilate. At approximately 1:06 a.m., a maternal intrauterine pressure catheter was inserted into the uterus. Petitioner contended that Respondent's faulty management of the Pitocin administration is evidenced by the recorded contraction baseline which indicates that the uterus remained tense between contractions. In his defense, Respondent offered the possibility that the internal pressure catheter had not been zeroed. Since this is a plausible explanation for an inaccurate reading, the Hearing Committee decided that Petitioner had not met its burden of establishing this allegation.

When Patient A reached full dilation at 2:15 a.m., the fetus was in the occiput posterior position. The accepted standard of care would have been for Respondent to instruct Patient A to push because the fetus may have descended or spontaneously rotated. Instead, Respondent attempted a forceps rotation at 2:15 a.m. and delivered the infant within twenty-four minutes. While Patient A's testimony does indicate her pushing efforts prior to full dilation, the record demonstrates that Respondent failed to allow her time to push when she was fully dilated and entering the second stage of labor. Although Respondent and Dr. Burkhart contended that the fetus was at risk, the fetal heart tracings show variability between the decelerations indicating that the fetus was receiving adequate oxygen. Respondent's contention that his use of forceps should have been reviewed by an individual who had significant experience with complex forceps deliveries misses the point. Respondent was not charged with inadequate skill or knowledge in the use of forceps. Rather, he was charged with performing a forceps operation without adequate medical indications.

In light of Respondent's testimony regarding the tightness of the nuchal cord, the Hearing Committee found Respondent's testimony that he was able to reduce the cord by slipping it over the baby's shoulder to be incredible. Further, Respondent acknowledged that residents are taught to clamp and cut the chord at the baby's neck in

such circumstances. In light of the infant's need for immediate resuscitation, Respondent's failure to cut the cord and transfer the infant immediately to the neonatal staff was a deviation from the accepted standard of care.

Patient A - 2003 Delivery

Patient A was scheduled for a cesarean section on December 15, 2003. On December 4, 2003, Respondent performed a non-stress test when her fetus was approximately 37 weeks and 1 day gestation. The Hearing Committee found Respondent's testimony that Patient A was "freaking out" when he entered the room was not credible in light of Patient A's testimony which indicated that she was not very concerned until Respondent told her that he thought she was going to have a baby that day and showed her the monitoring strip. The standard of care would have been to adequately assess the fetus by further monitoring of the fetal heart rate or by a biophysical profile.

The testimony of Respondent and his expert witness referenced a research correlation that had been made between grade three placentas and fetal lung maturity. Dr. Burkhart addressed consideration of this correlation in the context of whether an obstetrician should try to inhibit a person's labor or allow it to progress; however, the circumstances in this instance was an elective delivery prior to 39 weeks. The Hearing Committee determined that the standard of care was to determine fetal lung maturity by an adequate

assessment such as performing a biophysical profile or obtaining a specimen of amniotic fluid for a test for lung maturity. Delivering the infant without such an assessment exposed Patient A's infant to unnecessary risk.

Patient B

When Patient B reached the second stage of labor, she pushed for approximately three hours. Petitioner's allegation that Respondent failed to adequately manage Patient B's second stage of labor appears to be based upon a contention that Respondent was required to perform vaginal exams every hour while Patient B was pushing between 3:34 a.m. and 7:00 a.m. Petitioner's evidence that Respondent deviated from the standard of care in this regard, however, was equivocal.

The Statement of Charges contains an allegation that "Respondent rotated and/or delivered Patient B's fetus by multiple operative delivery devices contrary to accepted standards of medical care and/or failed to perform a cesarean section. The Hearing Committee agreed with the Department's expert that Respondent deviated from accepted standard of care when he used the vacuum extractor at a time when he could not determine the anatomical landmarks on the fetal head; however, the evidence presented did not establish that the use of multiple operative delivery devices was in itself a violation of the standard of care. Further, there was no

evidence that the standard of care required Respondent to perform a cesarean section at that time.

Patient C

Respondent ruptured Patient C's membranes when her cervix was two to three centimeters dilated, ninety percent effaced and the fetal head was at minus three station. Respondent contended that the medical indications for rupturing the membranes were that Patient C had planned to have a vaginal birth after cesarean (VBAC), was in pain, and her prior baby was nine pounds, seven ounces. As stated above regarding Patient A's 2001 delivery, however, Respondent exposed the patient to unnecessary risks including the possibility of umbilical cord prolapse when he artificially rupturing Patient C's membranes under these circumstances; thereby deviating from the accepted standard of care.

After thirty minutes of pushing, Patient C was making progress towards a spontaneous vaginal delivery with decent of the fetal head. The standard of care required Respondent to provide additional analgesia and permit her to push because the fetus may have spontaneously rotated. Instead, Respondent performed a forceps rotation and delivery creating further unnecessary risk. Permitting Patient C only one half hour to push was insufficient; no medical indication for the use of forceps existed at that time.

Patient D

Respondent assumed that Patient D was in her first trimester when she was first seen at his office on October 31, 2005. A transvaginal ultrasound was obtained, but the only measurement reported was the cervical length. A reasonably prudent physician would consider such an exam incomplete. Respondent's failure to order an abdominal ultrasound or some further evaluation of Patient D in order to date her pregnancy was a gross deviation from the accepted standard of care. The Hearing Committee also found that Petitioner had established factual allegations D-2, D-3, and D-4; however, the Committee considered those factual allegations to be subsets of factual allegation D-1.

When Patient D's HCG level did not double between the first and second visits as would be expected in the first trimester, Respondent assumed the pregnancy was nonviable and ordered the administration of Methotrexate to terminate the pregnancy. When the administration of Methotrexate did not expel the pregnancy, Respondent performed a dilation and curettage on November 23, 2005. In fact, Patient D was in her third trimester, and she had a spontaneous vaginal delivery of a 39-week infant on December 7, 2005. Throughout the course of his treatment, Respondent failed to consider Patient D's progesterone level which was repeatedly consistent with a third trimester pregnancy. At the hearing, Respondent failed to acknowledge responsibility for his failure to accurately diagnose

this third trimester pregnancy and his attempts to expel the pregnancy. Instead, Respondent blamed his misconduct on Patient D's misidentification of her last menstrual period, Patient D's obesity, the sonographer's incomplete ultrasound and the nurse practitioner's alleged failure to advise him of the high progesterone levels. Respondent's attempts to expel Patient D's pregnancy was a gross deviation from the accepted standard of care which created the risk of potentially grave consequences for Patient D and her infant.

Patient E

Patient E was approximately 17 weeks pregnant when she first came to Respondent's office. The Hearing Committee found that Respondent's use of tocolytics under the circumstances of Patient E's gestational age, her continued contractions and her subchorionic bleed was a significant deviation from the accepted standard of care. Although Respondent offered Dr. Stahl's testimony in support of his use of tocolytics, Dr. Stahl's anecdotal testimony concerning physicians at Crouse Hospital using tocolytics before 20 weeks gestation does not establish such conduct as an accepted standard of care in New York State.

Respondent placed a cerclage in Patient E's cervix when she had a chronic subchorionic bleed and was less than 19 weeks pregnant. His conduct was grossly negligent in that there was no medical indication for a cerclage, and the risk of placing the cerclage under

the circumstances included causing infection which could precipitate delivery, injure the bladder and injure the cervix. Although Dr. Stahl testified that cerclage can be potentially beneficial when a physician has eliminated other reasons for cervical change and has stopped the uterus from contracting, the record does not indicate that Patient E's uterus stopped contracting. Respondent should never have placed the cerclage, and his delay in removing it was egregiously negligent conduct.

It was obvious that patient E experienced significant blood loss during the time of her hospitalization. On the day Respondent discharged her, Patient E's hemocrit was 17.2 and hemoglobin was 6.1. At these values, Patient E was at risk of shock and death if she sustained any serious bleeding. Nonetheless, Respondent failed to institute treatment with an iron preparation until six days after the patient had been discharged. Respondent's attempt to blame nursing staff and communication of lab results within the hospital for his negligence in addressing this issue is plainly without merit. Under these circumstances in particular, Respondent had an affirmative obligation to look for the lab results, and his failure to do so was grossly negligent.

Patient F

Considering her prior medical history, it was likely that Patient F's adhesion was in a non-gynecologic region. She had had

four prior abdominal procedures and had known adhesional disease based on the findings of one of the prior surgeries. Respondent's contention that gynecological surgeons have as much if not more experience in relation to laparoscopic adhesion take down than general surgeons does not justify neglecting to seek out a consultation in light of Patient F's co-morbidities and the increased risk of bowel injury. Respondent's failure to obtain a pre-operative surgical consultation was a significant deviation from the accepted standard of care.

Respondent failed to adequately evaluate, manage, and treat Patient F post-operatively for the iatrogenic injury sustained during the laparscopy. When advised on the first post-operative day that Patient E had pain on her right side and fever, Respondent ordered Milk of Magnesia for at-home treatment of a possible ileus. The accepted standard of care required that Respondent instruct the patient to return to the hospital.

When Patient F was admitted to the hospital the following day, she had significant tachycardia, her bowel was significantly distended and her diabetes was out of control. Patient F could have died due to acute peritonitis from the bowel injury. Respondent's failure to obtain prompt surgical and medical consultations was a significant deviation from the accepted standard of care which endangered her life.

Factual Allegations

The vote of the Hearing Committee on the factual allegations contained in the Statement of Charges is as follows:

Paragraph A - A.1	Sustained (3-0)
Paragraph A - A.2	Not Sustained
Paragraph A - A.3	Sustained (3-0)
Paragraph A - A.4	Sustained (3-0)
Paragraph A - A.5	Sustained (3-0)
Paragraph A - A.6	Sustained (3-0)
Paragraph A - A.7	Sustained (2-1)
Paragraph A - A.8	Not Sustained
Paragraph B - B.1	Withdrawn
Paragraph B - B.2	Not Sustained
Paragraph B - B.3	Not Sustained
Paragraph B - B.4	Not Sustained
Paragraph C - C.1	Sustained (3-0)
Paragraph C - C.2	Sustained (2-1)
Paragraph C - C.3	Not Sustained
Paragraph D - D.1	Sustained (3-0)
Paragraph D - D.2	Sustained (3-0)
Paragraph D - D.3	Sustained (3-0)
Paragraph D - D.4	Sustained (3-0)
Paragraph D - D.5	Sustained (3-0)
Paragraph D - D.6	Not Sustained
Paragraph E - E.1	Sustained (3-0)
Paragraph E - E.2	Sustained (3-0)
Paragraph E - E.3	Sustained (3-0)
Paragraph E - E.4	Sustained (3-0)
Paragraph E - E.5	Sustained (3-0)
Paragraph E - E.6	Sustained (3-0)
Paragraph E - E.7	Not Sustained
Paragraph F - F.1	Sustained (3-0)
Paragraph F - F.2	Not Sustained
Paragraph F - F.3	Sustained (3-0)
Paragraph F - F.4	Sustained (3-0)
Paragraph F - F.5	Sustained (3-0)
Paragraph F - F.6	Not sustained

Specifications

The First through Sixth Specifications charged Respondent with practicing with gross negligence on a particular occasion, in violation of New York Education Law §6530(4) with respect to each of the named patients. As was discussed in detail above, the Hearing Committee found Respondent's treatment of Patients D, E and F demonstrated gross negligence. By a unanimous vote, the Fourth, Fifth and Sixth Specifications are **Sustained.** The First, Second, and Third Specifications are **Dismissed.**

The Seventh through Twelfth Specification charged Respondent with practicing with gross incompetence within the meaning of New York Education Law §6530(6). The Hearing Committee felt that Respondent was well trained and possessed the requisite knowledge and skill to practice safely. The Committee decided that Respondent's failure to practice medicine safely was due to his negligence rather than incompetence. As a result, the Seventh through Twelfth Specifications are **Not Sustained.**

The Thirteenth Specification charged Respondent with practicing the profession with negligence on more than one occasion, in violation of New York Education Law §6530(3). Given the fact that the Committee has found multiple instances of negligence involving five of the six patients whose care is at issue, the Thirteenth

Specification is **Sustained** by a unanimous vote.

The Fourteenth Specification charged Respondent with practicing with incompetence on more than one occasion, in violation of New York Education Law §6530(5). As stated above, the Committee concluded the record does not establish that Respondent's actions in regard to the allegations charged demonstrate incompetence. Accordingly, the Fourteenth Specification is **Not Sustained.**

The Fifteenth through Twentieth Specifications charged Respondent with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in violation of New York Education Law §6530(32). The Hearing Committee unanimously concluded that Respondent's records for each of the named patients was adequate. Accordingly, the Fifteenth through Twentieth Specifications are **Not Sustained.**

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license should be suspended for two years; however, after 30 days of actual suspension, the remainder of the period of suspension should be stayed provided that Respondent complies with certain terms of probation. The Committee determined further that Respondent's license to practice medicine as a physician in New York

State should be permanently limited to prohibit him from performing high forceps and midforceps rotations or deliveries. 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 Hearing Committee believes that Respondent has the requisite knowledge and skill to practice medicine safely, but that he has repeatedly failed to exercise the care that a reasonably prudent physician would exercise under the circumstances. The Committee sought to fashion a penalty that would permit Respondent to continue to practice his chosen profession while ensuring the safety of his patients.

The Committee feels that 30 days of actual suspension must be imposed to provide a period of time during which Respondent can reflect upon his prior misconduct and redirect his energy and focus towards practicing medicine within accepted standards. In addition, Respondent's inability to practice for that period of time will serve as a penalty by having a significant monetary impact.

A suspension of Respondent's license, stayed after 30 days for the remainder of a two-year period provided Respondent complies with terms of probation, is necessary to ensure that Respondent practices medicine within accepted standards. In spite of his

knowledge and skill, Respondent has managed the care of his patients in ways that expose them to unnecessary risk. Under the terms of probation, the Director of the Office of Professional Medical Conduct will be able to review Respondent's professional performance and take action if necessary.

The Committee believes that Respondent's license to practice medicine must also be limited to prohibit him from performing high forceps and midforceps rotations or deliveries. Although midforceps operations are within the accepted standard of care under appropriate circumstances, Respondent's conduct shows that he does not recognize the risks associated with their use. Respondent professes great skill in using forceps and seems to derive satisfaction from exhibiting this ability. His judgment concerning whether the appropriate circumstances for forceps use exist, however, appears clouded by his desire to display his professed ability. An example of Respondent's impaired judgment in this regard was evidenced by his persistence in performing midforceps operations in a hospital after his privileges to perform that operation were suspended. Respondent had other viable options to safely address the medical circumstances of his patients; however, he blatantly disregarded the terms imposed upon his hospital privileges, professing to do so out of necessity.

The Hearing Committee recognizes that this limitation will

remove one tool from Respondent's armamentarium; however, a cesarean section is an acceptable alternative. The reality is that many obstetricians practice safely within the accepted standard of care without performing midforceps operations. The Committee unanimously determined that Respondent's over-confidence and his unwillingness to alter his use of midforceps strongly dictates the imposition of a prohibition against their use.

The three sustained specifications of gross negligence, taken separately, would warrant the suspension and probation imposed. The sustained specification of negligence on more than one occasion, considered separately, would also warrant the suspension and probation imposed.

ORDER

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

1. The Fourth, Fifth, Sixth and Thirteenth Specifications of professional misconduct, as set forth in the Statement of Charges, (Exhibit #1) are **SUSTAINED**;

2. The First through Third, Seventh through Twelfth and Fifteenth through Twentieth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State is hereby **SUSPENDED FOR A PERIOD OF TWO YEARS**;

UPON COMPLETION OF THE FIRST THIRTY DAYS OF ACTUAL SUSPENSION, THE REMAINDER OF THE SUSPENSION PERIOD SHALL BE STAYED CONTINGENT UPON RESPONDENT'S COMPLIANCE WITH THE TERMS OF PROBATION which are annexed and attached hereto;

4. Respondent's license to practice medicine as a physician in New York State is hereby **PERMANENTLY LIMITED IN THAT HE IS PROHIBITED FROM PERFORMING HIGH FORCEPS AND MIDFORCEPS ROTATIONS OR DELIVERIES**; and

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Pittsford, New York
6 December, 2007

Redacted Signature

CHARLES J. VACANTI, M.D. (CHAIR)

RAJAN K. SRISKANDARAJAH
JEAN KRYM

TO: Timothy J. Mahar, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2512
Empire State Plaza
Albany, New York 12237

James R. Caputo, M.D.

Redacted Address

Michael Paul Ringwood, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street - Suite 600
Syracuse, New York 13202-1252

Terms of Probation

1. 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. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is 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. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if 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.

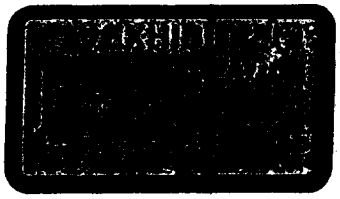
6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be

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. 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. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she 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.

APPENDIX I



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

IN THE MATTER

OF

JAMES R. CAPUTO, M.D.

NOTICE

OF

HEARING

TO: James R. Caputo, M.D.
Redacted Address

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on June 22, 2007, at 10:00 a.m., at the Holiday Inn, Exit 35, Carrier Circle, East Syracuse, New York 13057, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-

0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE

MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
May 10 ,2007

Redacted Signature

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to:

Timothy J. Mahar
Associate Counsel
Bureau of Professional Medical Conduct
Room 2512, Corning Tower
Empire State Plaza
Albany, New York 12237
(518) 473-4282

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

IN THE MATTER

OF

JAMES R. CAPUTO, M.D.

STATEMENT

OF

CHARGES

James R. Caputo, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 11, 1997, by the issuance of license number 206065 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided obstetrical and gynecological care to Patient A (all patients are identified by name in Appendix A hereto) during the period from February 28, 2001 through the present. On September 16, 2001, Respondent performed a forceps delivery on Patient A. Patient A's baby was delivered with Apgar scores of 0/0. On or about December 4, 2003, following a second pregnancy, Respondent delivered Patient A's fetus by Cesarean section at approximately 37 weeks, 2 days gestation. Respondent's medical care of Patient A deviated from accepted standards of medical care as follows:

September 2001 Delivery

1. Respondent, on September 15, 2001, ruptured Patient A's membranes without adequate medical indications and/or in circumstances where there was an increased risk of umbilical cord prolapse.

2. Respondent failed to appropriately manage the administration of Pitocin to Patient A.

3. Respondent attempted and/or performed a forceps rotation and/or a forceps delivery of Patient A's fetus without adequate medical indications.

4. Respondent, during the September 16, 2001 delivery, failed to appropriately and/or adequately manage the second stage of Patient A's labor.

5. Respondent failed to timely transfer Patient A's depressed baby to the pediatrician and/or neonatologist.

December 2003 Delivery

6. Respondent failed to adequately assess the fetus following a non-stress test on December 4,2003 and prior to performing a cesarean section.

7. Respondent, on December 4, 2003, delivered by cesarean section, Patient A's fetus at approximately 37 weeks +2 gestation without an adequate medical indication.

8. Respondent failed to maintain an adequate medical record for Patient A regarding the September 2001 and/or the December 2003 deliveries and/or the prenatal care for those deliveries.

B. Respondent provided gynecological and obstetrical care to Patient B at his offices and at Crouse Hospital, Syracuse, New York during the period including from October 14, 1999 to December 9, 2003. Respondent performed an operative vaginal delivery on Patient B on or about September 11, 2003. Respondent's medical care of Patient B deviated from accepted standards of medical care as follows:

1. Respondent failed to adequately evaluate Patient B for a coagulation disorder given her prior history of deep vein thrombosis which was unrelated to birth control medication. Withdrawn 7/27/07 WL.

2. Respondent failed to adequately manage Patient B's second stage of labor. 7/13/07 WL.

3. Respondent ~~attempted to~~ rotate and/or deliver Patient B's fetus by multiple operative delivery devices contrary to accepted standards of medical care and/or failed to perform a cesarian Section.

4. Respondent failed to maintain an adequate medical record for Patient B, including, but not limited to, Respondent's failure to adequately document Patient B's second stage of labor and/or the methods used to effect the delivery.

C. Respondent provided obstetrical and gynecological care to Patient C at his offices and at Crouse Hospital, Syracuse, New York during the period including March 5, 2003 through March 8, 2004. Respondent performed a

forceps delivery of Patient C on August 21, 2003. Respondent's medical care of Patient C deviated from accepted standards of medical care as follows:

1. Respondent ruptured Patient C's membranes prematurely and/or without adequate medical indications.

2. Respondent performed a forceps rotation and/or delivery of Patient C without adequate medical indications and/or contrary to accepted standards of medical care.

3. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided obstetrical and gynecological care to patient D at his offices and at Crouse Hospital, Syracuse, New York during the period including October 13, 2003 to December 9, 2005. On or about November 4, 2005, Patient D had a viable pregnancy in excess of 33 weeks. On or about November 4, 2005, Respondent misdiagnosed patient D with an approximately 8 to 9 week, non-viable pregnancy. On November 8, 2005, Respondent ordered Methotrexate be given to Patient D. On November 23, 2005, Respondent performed a suction dilation and curettage on Patient D. On December 7, 2005, Patient D had a spontaneous vaginal delivery of a 39 week male infant. Respondent's medical care of patient D deviated from accepted standards of medical care as follows:

1. Respondent failed to accurately diagnose Patient D's third trimester pregnancy on one or more occasions.

2. Respondent failed to adequately review and/or analyze and/or assess Patient D's serum progesterone levels.

3. Respondent failed to obtain and/or order an abdominal ultrasound evaluation of Patient D.

4. Respondent failed to adequately evaluate Patient D prior to treating her with IM Methotrexate.

5. Respondent treated patient D with IM Methotrexate and/or then performed a suction dilation and currettage for erroneous and/or inadequate medical indications. In the alternative, Respondent failed to document adequate medical indications.

6. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent provided obstetrical care to Patient E at his offices and at Crouse Hospital, Syracuse, New York during the period including June 9, 2004 to November 18, 2004. Patient E was approximately 17 4/7 weeks pregnant at the time of her treatment on June 9, 2004 and presented with signs and symptoms of a threatened second trimester abortion. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed to appropriately manage patient E's threatened abortion.

2. Respondent prescribed tocolytic agents in the treatment of Patient E inappropriately and/or without adequate medical indications.

3. Respondent placed a cervical cerclage in Patient E without adequate medical indications.

4. Respondent failed to timely remove the cervical cerclage from Patient E.

5. Respondent failed to timely and/or adequately treat Patient E's significant anemia at or about the time of Patient E's hospital discharge on July 10, 2004.

6. Respondent dictated on August 6, 2004 his summary of Patient E's hospital discharge on July 10, 2004. In that summary, Respondent suggests that he was aware of Patient E's anemia at the time of discharge, when in fact Respondent did not prescribe iron to Patient E until six days after her hospital discharge. Respondent's discharge summary is misleading, among other things.

7. Respondent failed to maintain an adequate and/or accurate medical record for Patient E.

F. Respondent provided medical care to Patient F during the period from April, 2000 through August, 2000 for complaints of right lower quadrant pain, among other conditions. On July 28, 2000, Respondent lysed adhesions in a laparoscopic procedure during which Respondent created and repaired a rent in the serosa of the small bowel and perforated the uterine fundus. Respondent's medical care of Patient F deviated from accepted standards of care in the following respects:

1. Respondent failed to obtain a pre-operative surgical consultation in view of Patient F's co-morbidities, and her increased risk of bowel injury, among other things.

2. Respondent failed to order a bowel prep for Patient F prior to the laproscopic surgery.

3. Respondent failed to adequately evaluate, manage, and/or treat Patient F intra-operatively and/or post-operatively for the iatrogenic injury or injuries sustained by Patient F during the laproscopic procedure on July 28, 2000.

4. Respondent failed to timely and/or adequately evaluate, manage, and/or treat Patient F following her discharge on July 28, 2000.

5. Respondent failed to obtain a timely surgical consultation following Patient F's admission to Crouse Hospital on July 30, 2000.

6. Respondent failed to maintain an adequate medical record for Patient F.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS
GROSS NEGLIGENCE

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

1. The facts set forth in the following paragraphs: A and A.2 and/or A and A.3.
2. The facts set forth in the following paragraphs: B and B.2 and/or B and B.3.
3. The facts set forth in the following paragraphs: C and C.1 and/or C and C.2.
4. The facts set forth in the following paragraphs: D and D.1 and/or D and D.2, and/or D and D.3, and/or D and D.5.
5. The facts set forth in the following paragraphs: E and E.1 and/or E and E.2, and/or E and E.3, and/or E and E.5.
6. The facts set forth in the following paragraphs: F and F.1 and/or F and F.2, and/or F and F.3, and F and F.4, F and F.5.

SEVENTH THROUGH TWELFTH SPECIFICATIONS
GROSS INCOMPETENCE

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

7. The facts set forth in the following paragraphs: A and A.2 and/or A and A.3.

8. The facts set forth in the following paragraphs: B and B.2 and/or B and B.3.

9. The facts set forth in the following paragraphs: C and C.1 and/or C and C.2.

10. The facts set forth in the following paragraphs: D and D.1 and/or D and D.2, and/or D and D.3, and/or D and D.5.

11. The facts set forth in the following paragraphs: E and E.1 and/or E and E.2, and/or E and E.3, and/or E and E.5.

12. The facts set forth in the following paragraphs: F and F.1 and/or F and F.2, and/or F and F.3, and/or F and F.4, and/or F and F.5.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(3) by reason of his having practiced medicine with negligence on more than one occasion, in that Petitioner charges:

13. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(5) by reason of his having practiced medicine with incompetence on more than one occasion, in that Petitioner charges:

14. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

FIFTEENTH THROUGH TWENTIETH 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:

15. The facts set forth in the following paragraphs: A and A.8.
16. The facts set forth in the following paragraphs: B and B.4.
17. The facts set forth in the following paragraphs: C and C.3.
18. The facts set forth in the following paragraphs: D and D.6.
19. The facts set forth in the following paragraphs: E and E.6, and/or E and E.7.
20. The facts set forth in the following paragraphs: F and F.6.

DATED: May 10, 2007
Albany, New York

Redacted-Signature

Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct