Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 8, 2011

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Suarna Mehulic, M.D.
REDACTED

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

RE: In the Matter of Suarna Mehulic, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 11-140) 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

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

OF

SUARNA MEHULIC, M.D.

DETERMINATION

AND

ORDER

BPMC #11-140

JOAN MARTINEZ McNICHOLAS, Chairperson, ELISA BURNS, M.D. and ARLIE CAMERON, M.D., MPH, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. CHRISTINE C. TRASKOS, ESQ., served as Administrative Officer for the Hearing Committee. The Petitioner, also referred to as the Department of Health, appeared by JAMES E. DERING, ESQ., General Counsel, CHRISTINE RADMAN, ESQ., Associate Counsel, of Counsel. The Respondent, SUARNA MEHULIC, M.D., appeared PRO SE. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged ten (10) specifications of professional misconduct, including allegations of negligence on more than one occasion, incompetence on more than one occasion, fraudulent practice, false reporting and failure to maintain records. The charges

are more specifically set forth in the Statement of Charges, dated December 3, 2010, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order. Respondent filed an Answer, dated January 16, 2011 and denied all allegations.

SUMMARY OF PROCEEDINGS

Pre-Hearing Conference:	January 20, 2011
Hearing Dates:	February 3, 2011
	March 2, 2011
Deliberation Date:	April 26, 2011

WITNESSES

For the Petitioner:	Robert F. Porges, M.D.
	Anca Rosca, M.D.
	Sylvia Nagy, M.D.
	Farzaneh Nabizadeh, M.D.
For the Respondent:	Suarna Mehulic, M.D.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These Findings represent documentary evidence and testimony found persuasive by the Hearing Committee. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable, or credible in favor of the cited evidence. The Petitioner-Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings, and all Findings were established by at least a preponderance of the evidence.

1. SUARNA MEHULIC, M.D., the Respondent, was a "licensee," as that term is defined in N.Y. Pub. Health Law §230(7)(a), from July 1, 2007 through on or about April 18, 2008, and is referred to as "licensee" although she does not hold, and has not held, a license to practice medicine in New York State as issued by the New York State Education Department. During the stated period, Respondent was a Post Graduate Year 2 (PGY2) resident in the Department of Obstetrics and Gynecology (OB/GYN) at New York Downtown Hospital (NYDH) in New York, New York, and in that capacity was involved in the care and treatment of Patients A through I. (Dept. Ex.1)

2. Respondent graduated from medical school in Zagreb in the former Yugoslavia in 1995 and settled permanently in this country in 2000. Respondent provided no information as to where or for how long she worked as a physician, if at all, between 1995 and 2000. (Resp. Ex. 15; pp. 25-26)

3. Respondent was accepted into the OB/GYN residency program at Tufts University in Massachusetts for the 2006-2007 academic year only. (Resp. Ex. 15; pp. 31-37; Dept. Ex. 18)

4. Respondent began the second year of her OB/GYN residency (PGY2) at New York Downtown Hospital in New York, New York on July 1, 2007.(Dept. Ex. 2)

5. The OB/GYN residency program at NYDH is four years long, consisting of junior (PGY1 and 2) and senior (PGY3 and 4) residents. It is critically important to proper medical education and training as well as patient care that the chain of command from attending physicians down through the ranks be respected and maintained in all teaching hospitals and medical facilities throughout the United States. (T. pp. 31-34, 90-93)

6. Respondent was placed on probation at NYDH on January 31, 2008 and was terminated from the residency program on April 18, 2008. (Resp. Exs. H, I, K and Q, p. 3)

PATIENT A

7. The Factual Allegations and corresponding Specifications of Charges related to this patient have been withdrawn by the Department, as the testimony of the fact witness supporting such facts and charges could not be obtained.

PATIENT B

8. Chorioamnionitis is an infection of the placenta and membranes that surround the fetus. Such infection is the risk associated with a significant length of time transpiring between the rupture of membranes and actual delivery. This infection can be very serious, even fatal, for the fetus or the mother. (T. pp. 41-42)

9. The standard of care requires that pelvic examinations of such patients be limited to only when medically necessary, due to a change in the patient's or fetus' clinical condition, to decrease the risk of chorioamnionitis. (T. p. 43)

10. On or about July 6, 2007, Patient B was admitted to labor and delivery at less than 35 weeks gestational age in pre-term labor. Shortly thereafter, her membranes ruptured. The morning of July 7, 2007, Respondent was directed by her senior resident, Dr. Farzaneh Nabizadeh, not to perform a pelvic examination on Patient B as her membranes had ruptured, so she was at increased risk for chorioamnionitis, and a pelvic exam was already performed that morning at 7:25 AM. (Dept. Ex. 4, p. 25 ;T. pp. 273-278, 283-286)

11. Dr. Nabizadeh stated that while there was a risk of possible infection, she did not think one exam is going to do any major damage. (T. 278)

PATIENT C

12. A nonreassuring fetal heart rate tracing includes one that deviates dramatically from the norm, which is generally from 120 to 160 beats per minute.(T. pp. 49-50)

13. Umbilical cord prolapse is a condition in which the umbilical cord protrudes through the patient's cervix, below the presenting part of the baby. This presents a danger of cord compression, which could deprive the baby of sufficient oxygen resulting in serious consequences. (T. pp. 50-51)

14. Once a medical professional appreciates such a condition, the standard of care is to remain with the patient to prevent the baby's head from compressing the umbilical cord. (T. pp. 51-54)

15. On or about November 1, 2007, Patient C was admitted to labor and delivery and found to have a Nonreassuring Fetal Heart Rate Tracing (NRFHT). Respondent performed a vaginal examination on Patient C with a nurse in the room.(Dept. Ex. 16)

PATIENT D

16. The Factual Allegations and corresponding Specifications of Charges related to this patient have been withdrawn by the Department, as the testimony of the fact witness supporting such facts and charges could not be obtained.

PATIENT E

17. Patient E came to NYDH on January 2, 2008 for an elective myomectomy via laparotomy for the removal of any diseased tissue. She consented to a possible total abdominal hysterectomy should it have proved medically necessary. (Dept. Ex. 7, p. 93)

18. The gynecology team for that month of January consisted of chief resident Angela Sturdivant, M.D., PGY2, Suarna Mehulic, M.D., and PGY1, Sylvia Nagy, M.D. During gynecology rounds on the morning of January 4, 2008, Patient E experienced symptoms for which an abdominal x-ray was ordered and entered into the electronic medical record by Dr. Nagy.(Dept. Ex. 7, p. 29 and 160;(T. pp. 144-146)

19. The January 4, 2008 abdominal x-ray revealed "free peritoneal air...multiple dilated small bowel loops with air-fluid levels, compatible with early small bowel obstruction or postoperative ileus." (Dept. Ex. 7, p. 211)

20. During afternoon rounds the same day, the chief resident asked Dr. Mehulic to report on the results on the imaging study previously ordered for Patient E. She responded that the CT scan was normal. (T. pp. 150-151)

21. Dr. Nagy questioned Dr. Mehulic's oral report so the team went to the computer and brought up the imaging study, which in fact was an x-ray not a CT scan. The x-ray showed abnormalities in Patient E's abdomen. At that point, the patient received an nasogastric (NG) tube to help relieve her discomfort and possibly the ileus or obstruction, and was classified NPO (nothing by mouth).(Dept. Ex. 7, p. 30;T. pp. 152-153)

22. A delay in the diagnosis of Patient E's post-operative complication would have delayed appropriate treatment and exposed this patient to increased pain and risk of sepsis or death of bowel. (T. pp. 67-68, 152-153)

23. Patient E ultimately had small bowel obstruction surgery with lysis of adhesions, no resection, on January 15, 2008. (Dept. Ex. 7, pp. 151-152;T. p. 152-153)

PATIENT F

24. Patient F was admitted to Labor and delivery at NYDH on February 27, 2008, after she had a spontaneous pre-term rupture of membranes. She delivered vaginally on March 1 at 9:40 AM. (Dept. Ex. 8, pp. 13, 38)

25. On March 1 at 4:40 PM, Respondent examined Patient F post partum then called the attending at home within 20 minutes to report heavy vaginal bleeding, which is a potentially dangerous situation for the patient. Respondent ordered a CBC for the patient and then

Dr. Nabizadeh got involved in assisting the patient. (Dept. Ex. 8, p. 45, 58;T. pp.239-242)

PATIENT G

26. Patient G went to the NYDH Emergency Department reporting a positive home pregnancy test and complaining of dizziness, nausea without vomiting, no vaginal bleeding and crampy abdominal pain. Respondent was the resident assigned to her care. (Dept. Ex. 9, p. 4-5)

27. Human chorionic gonadotropin (beta HCG) hormone level is a quantitative test that determines whether or not a patient is pregnant and, if so, whether the exact number obtained is consistent with the clinical examination and a healthy ongoing pregnancy. There is no "preliminary" beta HCG hormone level. The standard of care required a determination as to whether or not Patient G's pregnancy was intrauterine or ectopic, the latter of which could result in maternal death. An accurate reporting of the beta HCG level is essential to this differential diagnosis. Patient G's blood was drawn to obtain the beta HCG number. (T. pp 73-74)

28. Respondent acknowledged that she documented an incorrect beta HCG hormone level of 4388, which was the extension number for the lab at NYDH which provides the results. Patient G was released from the ED based on this incorrect number. (Dept. Ex. 9, p. 5;T. p. 293)

29. The correct beta HCG level for Patient G's blood draw was 16,246. Once that was discovered, Respondent crossed out "qualitative 4388" and added "preliminary report" next to the incorrect entry in Patient G's medical record. (Dept. Ex. 9, p.5)

PATIENT H

30. On or about March 26, 2007, Patient H was in a NYDH operating room for a planned myomectomy, bilateral cystectomy and possible hysterectomy. Respondent was the junior resident assigned to her case and was directed to prepare the patient for surgery. (Dept. Ex. 10, pp. 2, 21)

31. The standard of care when prepping a surgical patient with betadine for the

gynecological procedures outline above is to use a separate sponge for the vagina and those areas beyond the vagina. The vagina is not sterile, therefore using the sponge to prep the vagina over the planned abdominal incision site(s) might contaminate the peritoneal cavity and expose the patient to unnecessary risk. (T. pp 77-80)

32. Respondent prepped Patient H's vagina with betadine and continued with the same sponge to prep the skin of the patient's abdomen and thighs. First, the senior scrub nurse and then the senior resident instructed her to prep the patient anew and properly by using separate sponges for the vagina and areas beyond the vagina. After some resistance on Respondent's part, the patient was properly prepped. (Dept. Ex. 17;T. p 296-300)

PATIENT I

33. On or about April 3, 2008, Respondent was the junior resident assigned to an OB/GYN service patient, Patient I. Respondent took the patient's history, performed a physical examination and admitted her in active labor to Labor and Delivery at 9:15 AM. Anca Rosca, M.D. was the attending physician overseeing the case. (Dept Ex.11, pp. 7-10)

34. The custom and practice at NYDH for the delivery of service patients, without private physicians, is for residents to take charge of such patients through delivery with an attending nearby or scrubbing in to assist, if necessary. (T. p 103)

35. At approximately 10:40 AM, there was a deceleration noted in the fetal heartbeat, which needed to be strictly monitored. An internal fetal monitor was placed on the baby's head as an external one could not adequately pick up the baby's heartbeat when Patient I, refusing pain medication, began moving all over the bed and writhing in pain. (Dept Ex. 11, p 15;T. pp. 104-106)

36. By approximately 12:40 PM, Patient I was not pushing effectively and the fetal heart rate was in the 90s, which is outside of the normal range. Respondent was present to deliver with

Dr. Rosca supervising, with both physicians between the patient's legs. (Dept. Ex. 11, p. 18)

37. Patient I was very uncooperative and could not even be safely injected with lidocaine for an episiotomy, which is an incision into the perineum and vagina to allow sufficient clearance for birth. Dr. Rosca asked Respondent for a scissor to make the cut. Respondent then cut the leads to the internal fetal monitor, leaving the medical team without any information as to the baby's condition. (T. p. 112)

38. The head was delivered after Dr. Rosca performed the episiotomy and Respondent grabbed the head but had difficulty delivering the shoulders. At this point, Dr. Rosca took over the delivery and asked Respondent to apply suprapubic pressure to facilitate the delivery of the shoulders, but she applied it improperly. Dr. Rosca instructed Respondent to stop as she was impeding the delivery of the shoulders. Another physician, Dr. Delgado applied the proper pressure and the shoulders and rest of the baby were delivered at 12:42 PM. (T. pp. 113-115)

39. After the baby was delivered, Respondent failed to attend to Patient I in the delivery of her placenta, collecting cord blood for the nursery or the repair of her episiotomy. She remained standing by the baby as he was being cared for by other hospital staff. (T. pp. 115-116)

40. The delivering resident has the responsibility to complete the Labor Record at NYDH including the delivery note which outlines the events during the delivery. Other information on the form, such as the time of delivery, sex and weight of baby, apgar score, and resident and attending names may be filled in by another resident from information already in the chart.(T. pp. 119)

41. PGY1, Sylvia Nagy. M.D., began charting information in Patient I's Labor Record shortly after the delivery. (Dept. Ex. 11a)

42. Dr. Nagy approached Dr. Rosca as soon as she came out of the delivery room and told Dr, Rosca that Respondent instructed her to cross Respondent's name off Patient I's Labor

Record, stating that she "did not do anything in that delivery." Respondent herself corroborated this account and acknowledged that she had her name crossed off Patient I's Labor Record. (Dept. Ex. 11a;T. pp. 120-123, 132-133, 203)

43. Dr. Rosca presented the altered medical record to NYDH OB/GYN chief, Allan Klapper, M.D., to ask him how this situation should be handled. He instructed her to rewrite the medical record to accurately reflect the care and treatment of Patient I. After doing so, Dr. Rosca signed the form as the attending, which is the only signature that the form requires.(Dept. Ex. 11, p. 20;T. pp. 123-127)

CONCLUSIONS OF LAW

Respondent is charged with ten (10) 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 relevant to this proceeding. 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, incompetence and the fraudulent practice of medicine.

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

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

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

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. The Hearing Committee must find that (1)

a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. The licensee's knowledge and intent may properly be inferred from facts found by the Hearing Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that one (1) of ten (10) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties.

Robert F. Porges, M.D. testified for the Department as an expert witness. Dr. Porges is board certified in Obstetrics and Gynecology and has taught at New York University School of Medicine since 1962. Dr. Porges has published numerous scholarly research articles. The Hearing Committee found Dr. Porges to be a well qualified and credible witness with many years of experience .The Hearing Committee found his testimony persuasive regarding the general hierarchy of responsibility in a hospital residency program. They note however, that many of the hypothetical questions that were posed to him were not ultimately supported by the facts in the record before the Hearing Committee.

Anca Rosca, M.D., an attending physician in the OB/GYN Department at NYDH since 2003, also testified. Dr. Rosca received her medical degree from Boston University and her residency training from NYDH (formerly NYU Downtown hospital). She worked with Respondent when Respondent was a PGY2 at NYDH in 2007/2008. The Hearing Committee found Dr. Rosca to be

a credible witness who testified with great consistency and detail particularly with respect to Patient I's delivery procedures.

Sylvia Nagy, M.D., who is currently a chief resident in the OB/GYN Department at NYDH, also testified for the Department. Dr. Nagy was a PGY1 there when Respondent was a PGY2 in 2007/2008. The Hearing Committee found Dr. Nagy to be a credible witness who testified in detail regarding the charge related to Patient E.

Farzaneh Nabizadeh, M.D., who was a senior resident in the OB/GYN Department at NYDH when Respondent was a PGY2 in 2007/2008, also testified for the Department. The Hearing Committee found Dr. Nabizadeh to be a credible witness.

Respondent testified on her own behalf. The Hearing Committee found that Respondent was not a credible witness. She testified with an overtone of persecution and frequently blamed others. The Hearing Committee found that her testimony was often paranoid and unfocused. Respondent believed there was a conspiracy against her at NYDH but the Hearing Committee found no proof of this in the record, nor in the testimony of any of the Department's witnesses.

Factual allegations A and A.1 :	**WITHDRAWN**
Factual allegations B and B.1 :	**NOT SUSTAINED**
Factual allegations C and C.1 :	**NOT SUSTAINED**
Factual allegations D and D.1:	**WITHDRAWN**
Factual allegations E and E.1:	**SUSTAINED**
Factual allegations F and F.1:	**NOT SUSTAINED**
Factual allegations G and G.1:	**NOT SUSTAINED**
Factual allegations H and H.1:	**SUSTAINED**
Factual allegations H and H.2:	**SUSTAINED**
Factual allegations I and I.1:	**NOT SUSTAINED**
Factual allegations I and I.2:	**SUSTAINED**
Factual allegations I and I.3:	**NOT SUSTAINED**

Factual allegations I and I.4a: **NOT SUSTAINED**

PATIENT A

The Department withdrew the charges regarding Patient A.

PATIENT B

The Hearing Committee notes that there is confusion in the records for Patient B (Ex.4) particularly regarding the status of the patient's ruptured membranes. More importantly, the Hearing Committee finds that even Dr. Nabizadeh stated "I don't think one exam is specifically going to do any major damage, but the more examinations are done the more chance of infection..." (T. 278) As a result, The Hearing Committee does not find sufficient evidence in the record to sustain this charge.

PATIENT C

The Hearing Committee notes that there are discrepancies in the facts regarding this charge. The patient's record does not support the fact that the patient had a Nonreassuring Fetal Heart Rate Tracing (NRFHT) when Respondent first saw her. The affidavit from Dr. Muelenberg states that during her initial exam, the fetal heart rate was initially normal, but during her exam became bradycardic when contact was made with the cord protruding through the cervix. There is further discrepancy in that Respondent testified that she did not leave the room and Dr. Muelenberg's affidavit states that she did. Since Dr. Muelenberg did not appear at the hearing, the Hearing Committee was unable to resolve this discrepancy with the evidence presented. They further note that Respondent did not truly abandon the patient because the nurse remained with the patient if Respondent left to get assistance. The Hearing Committee concludes that the Department has failed to prove the allegation regarding Patient C.

PATIENT D

The Department withdrew the charges regarding Patient D.

PATIENT E

The Hearing Committee sustains this charge that Respondent incorrectly reported both the nature and result of an imaging study ordered for Patient E to senior staff. The Hearing Committee believes Dr. Nagy's testimony that Respondent erroneously reported that a test that was never performed, i.e ,the CT scan, was normal when in fact the test that was performed, the x-ray, revealed a dilated loop bowel.(T. 151-152) The Hearing Committee rejects Respondent's

explanation that this event could not have happened because Dr. Sturdivant, the senior resident, gave Respondent a good review. The Hearing Committee finds that just because Dr. Sturdivant did not mention it in her report, this does not mean the incident did not happen. As a result ,the Hearing Committee sustains the charge as an act of incompetence under the Second Specification.

PATIENT F

The Hearing Committee finds that the record demonstrates that Respondent followed the directives of Dr. Rosca by ordering the CBC and that Dr. Nabizadeh , a senior resident intervened in the patient's care within 20 minutes. (Dept. Ex. 8, p. 45, 58) While Dr. Rosca may have received an untimely update on the status of her patient, the Hearing Committee finds no evidence in the record to support this charge against Respondent.

PATIENT G

The Respondent acknowledges and the record supports that she first recorded the beta H CG hormone level as "4388", but later double checked with the lab and was informed that the reading was "16,246". (Dept. Ex. 9, p.5;T. 248) The Hearing Committee finds that it was wrong for Respondent to label the first report as preliminary and that the record was imperfectly corrected. They note that the record was not destroyed or the information "whited out". The Hearing Committee finds insufficient evidence that Respondent acted with intent to deceive. As a result, the specifications of misconduct on these factual allegations are not sustained.

PATIENT H

The Hearing Committee finds that the affidavit of John Seitz, M.D., (Dept. Ex. 17) the anaesthesiologist corroborates the testimony of Dr. Nabizadeh that Respondent prepped Patient H in a manner that was clearly below the standard of care. Dr. Seitz also raised concern for Respondent's "resistance to take appropriate instruction." The Hearing Committee concurs with Dr. Porges that Respondent as a PGY2 is required to take directives from the senior resident in this instance.(T. 79-80) The Hearing Committee sustains both charges as acts of incompetence by Respondent under the Second Specification.

PATIENT I

Dr. Rosca testified that she asked Respondent for a scissor to cut an episiotomy, but Respondent instead cut the internal fetal electrode.(T.112) Respondent does not remember cutting the fetal monitoring wire.(T. 212) The Hearing Committee believes that there may have been a

misunderstanding between both physicians about what to cut during a hectic situation where the patient was writhing in pain and moving up and down in the bed. The Hearing Committee finds that there is insufficient evidence to sustain charge I.1.

The Hearing Committee however sustains charge I.2, because Respondent did not follow Dr. Rosca's instruction to apply suprapubic pressure to Patient I because the record indicates that Dr. DelGado had to step in to provide the appropriate procedure. (T. 114-115) As a result, the Hearing Committee sustains this charge as an act of incompetence under the Second Specification.

The Hearing Committee does not sustain charge I.3 because they do not believe that the evidence shows that Respondent abandoned Patient I. It appears that Respondent was pushed aside when Dr. DelGado stepped in and Respondent was never asked to come back to the delivery room. Finally, the Hearing Committee does not sustain charge I. 4. The Hearing Committee finds that Respondent assisted in the delivery but she did not deliver the baby. While Respondent may have violated hospital policy, they find no intent to deceive and the record was appropriately corrected as per Dr. Klapper's instruction. (Dept. Ex. 11A)

First Specification:

NEGLIGENCE ON MORE THAN ONE OCCASION- Not sustained

Second Specification:

INCOMPETENCE ON MORE THAN ONE OCCASION -Sustained

(Patients E, H and I)

Third and Fourth Specifications:

FRAUDULENT PRACTICE- Not Sustained

Fifth through Seventh Specifications:

FALSE REPORT - Not Sustained

Eight through Tenth Specifications:

FAILURE TO MAINTAIN RECORDS - Not Sustained

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that if Respondent applies for a license in New York State, the issuance of that license shall be subject to Respondent's submission to a psychiatric evaluation.

In addition, if Respondent is deemed impaired after the evaluation, she shall successfully complete a course of therapy and treatment that will enable her to safely practice medicine in New York State. The Director of the Office of Professional Medical Conduct (OPMC) shall set the conditions of the aforesaid treatment and name the treating psychiatrist. If the course of treatment and therapy is completed to the satisfaction of the Director of OPMC, then Respondent shall be permitted to apply for a license to practice medicine in New York State subject to any terms of probation set forth by OPMC. This determination was reached on due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interest of justice.

The Hearing Committee finds that Respondent demonstrated a lack of skill in three cases involving OB/GYN care. The Hearing Committee however is more seriously concerned with Respondent's ability to deal with supervision and common hospital protocols and polices. The Hearing Committee finds that the testimony of the Department's witnesses and even the evidence provided by Respondent herself does not support Respondent's theory that "they were out to get her" at NYDH. The Hearing Committee finds that Respondent does not follow rules and resists instructions from supervisors. Respondent then reacts in a paranoid fashion and blames others. This behavior was exhibited in her testimony at the hearing as well as in the recording of her conversation with her OB/GYN Department Director (Dr. Klapper) that was reviewed by the Hearing Committee. (Dept. Ex. 11) The Hearing Committee concludes that it is in the best interests of Respondent, as well as her future patients, if she is subjected to a psychiatric evaluation before any medical license is issued to her in New York State.

ORDER

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

1. The First, and Third through Tenth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Department's Exhibit #1), are **NOT SUSTAINED**; and

2. The Second Specification of Professional Misconduct, as set forth in the Statement of Charges (Department's Exhibit #1), is **SUSTAINED**; and

3. In the event that Respondent applies for a license in New York State, that **LICENSE SHALL BE SUBJECT TO THE FOLLOWING CONDITIONS:**

A. Respondent shall submit to a psychiatric evaluation; and

B. If Respondent is deemed impaired as a result of the psychiatric evaluation, then Respondent shall successfully complete a course of therapy and treatment that will enable her to safely practice medicine in New York State; and

C. The Director of OPMC shall set the conditions of treatment and name the treating psychiatrist; and

D. If the course of Respondent's treatment and therapy is completed to the satisfaction of the Director of OPMC, then Respondent's application process shall continue, and if she is granted a license to practice medicine in New York State, her license shall be subject to any terms of probation set forth by OPMC; and

4. OPMC shall be responsible to notify the New York State Department of Education regarding the restrictions placed on Respondent's license application and;

5. This Order shall be effective on service on the Respondent by personal service or by certified or registered mail.

DATED: New York, New York
June 8 2011

REDACTED

JOAN MARTINEZ McNICHOLAS
(Chairperson)
ELISA E. BURNS, M.D.
AIRLIE CAMERON, M.D., MPH

To:
Suarna Mehulic, M.D.
4523 Fairway Street
Dallas, Texas 75219

Christine Radman, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street- 4th Floor
New York, NY 10007

APPENDIX I

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

IN THE MATTER

OF

SUARNA MEHULIC, M.D.

NOTICE

OF

HEARING

TO: SUARNA MEHULIC
REDACTED

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 January 20, 2011, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, New York, New York 10007, 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 who shall be an attorney admitted to practice in New York state. 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.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here_____

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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. JAMES HORAN, ACTING 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: New York, New York
December 3, 2010

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Christine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007
(212)417-4450

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

IN THE MATTER

OF

SUARNA MEHULIC, M.D.

STATEMENT

OF

CHARGES

SUARNA MEHULIC, M.D., the Respondent, was a "licensee," as that term is defined in N.Y. Pub. Health Law §230(7)(a), at times in and about 2007 through in and about 2008, and is referred to as "licensee" although she does not hold, and has not held, a license to practice medicine in New York State issued by the New York State Education Department. At times in and about 2007 through in and about 2008, Respondent was a PGY 2 resident in the Department of Obstetrics and Gynecology at New York Downtown Hospital (NYDH) in New York, New York, and in that capacity was involved in the care and treatment of Patients A through I.

FACTUAL ALLEGATIONS

A. On or about July 6, 2007, Patient A was scheduled for an induction at NYDH. Respondent failed to meet the medically acceptable standard of care in that she:

1. Documented the patient's cervix as closed, high and thick before she arrived at the hospital and before examining her.

withdrawn by Dept 3/2/11 CCT

B. On or about July 8, 2007, Patient B was admitted to labor and delivery at less than 35 weeks gestational age with pre-term premature rupture of membranes (PPRM). Respondent failed to meet the medically acceptable standard of care in that she:

EXHIBT
Dept 1 Ex
1-20-11 MD

1. Performed a vaginal examination on Patient B, despite a senior staff directive, less than an hour before, to refrain from performing such exam due to the patient's increased risk for chorioamnionitis. From the time of the directive to the time Respondent performed the vaginal exam, Patient B' condition did not change.

C. On or about November 1, 2007, Patient C was admitted to labor and delivery and found to have a Nonreassuring Fetal Heart Rate Tracing (NRFHT). Respondent performed a vaginal examination on Patient C with a nurse in the room. Respondent failed to meet the medically acceptable standard of care in that she:

1. Withdrew her hand from the patient's vagina, after perceiving a cord prolapse, and left the room to seek help.

withdrawn by Dept 3/2/11

D. On or about November 22, 2007, Respondent was assisting a senior resident in a vacuum assisted delivery. After the delivery of the baby and the placenta, Patient D experienced moderate bleeding. Respondent failed to meet the medically acceptable standard of care in that she:

1. Left the delivery room and called a "Code White" without being instructed to do so by senior staff.

E. On or about January 4, 2008, Patient E was seen on rounds by the staff of the gynecology team. Respondent failed to meet the medically acceptable standard of care in that she:

1. Incorrectly reported both the nature and result of an imaging study ordered for Patient E to senior staff.

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F. On or about February 27, 2008, Respondent examined Patient F post partum then called the attending at home to report heavy vaginal bleeding. Respondent failed to meet the medically acceptable standard of care in that she:

1. Failed to follow the directives of the attending physician personally or delegate such directives.

G. On or about March 10, 2008, Patient G came to the ER six weeks pregnant complaining of pain, dizziness and bleeding. Respondent evaluated her and failed to meet the medically acceptable standard of care in that she:

1. Documented an incorrect serum human chorionic gonadotropin (HCG) hormone level, based upon which Patient G was initially inappropriately discharged and
2. Falsely added "preliminary" next to her incorrect entry in Patient G's medical chart, after the error was discovered by senior staff.
   a. Respondent intended to deceive

H. On or about March 26, 2008, Respondent was in the OR and directed by senior staff to prep Patient H for a planned myomectomy, bilateral ovarian cystectomy and possible hysterectomy. Respondent failed to meet the medically acceptable standard of care in that she:

1. Prepped the patient's vagina with betadine and continued with the same sponge to prep the skin of the patient's abdomen and thighs and
2. Resisted the correction of senior staff to use separate sponges for the vagina and areas beyond the vagina.

I. On or about April 3, 2008, Respondent evaluated and admitted Patient I to

labor and delivery. During and after the delivery of Patient I's baby, Respondent failed to meet the medically acceptable standard of care in that she:

1. Inappropriately cut the internal fetal scalp electrode,
2. Inappropriately provided pressure to Patient I's abdomen,
3. Failed to properly attend to Patient I immediately post-delivery and
4. Crossed her name off the delivery record being prepared by a junior resident.
   a. Respondent intended to deceive.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A through I and their respective subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A through I and their respective subparagraphs.

THIRD AND FOURTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs G, G.2 and G.2.a.

4. Paragraphs I, I.4 and I.4.a.

FIFTH THROUGH SEVENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

5. Paragraphs A and A.1.

6. Paragraphs G and G.1.

7. Paragraphs I and I.4.

EIGHTH THROUGH TENTH 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:

8. Paragraphs A and A.1.

9. Paragraphs G and G.1

10. Paragraphs I and I.4.

DATE: December 3, 2010
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct