



STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

May 28, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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NYS Department of Health
ESP-Corning Tower-Room 2509
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Richard D. Semeran, M.D.
5 Signal Hill Road
Fayetteville, New York 13090

RE: In the Matter of Richard D. Semeran, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-134) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee 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,



Tyfone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER
OF
RICHARD D. SEMERAN, M.D.,
Respondent

DETERMINATION
AND
ORDER

BPMC #03-134

COPY

The undersigned Hearing Committee (hereinafter referred to as "the Committee") consisting of **CHARLES J. VACANTI, M.D.**, Chairperson, **LEMUEL ROGERS, M.D.** and **WILLIAM WALENCE, PhD**, was duly designated and appointed by the State Board for Professional Medical Conduct (hereinafter referred to as "the State" or "Petitioner").

FREDERICK ZIMMER, ESQ., served as Administrative Law Judge.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307, 401 and 501 of the New York State Administrative Procedure Act. The purpose of the hearing was to receive evidence concerning alleged violations of Section 6530 of the New York State Education Law by **RICHARD D. SEMERAN, M.D.** (hereinafter referred to as "Respondent").

The Petitioner appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, **CINDY MARIE FASCIA, ESQ.**, of Counsel. Respondent appeared by **SMITH, SOVIK, KENDRICK & SUGNET, P.C.**, **MICHAEL P. RINGWOOD, ESQ.**, of Counsel.

Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

There were numerous motions and/or briefs which are all part of the record herein whether submitted to the Committee or not. The Committee has considered the entire evidentiary record, including exhibits and testimony, in the above captioned matter and hereby renders its decision.

RECORD OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges:	1/23/03
Respondent's Answer Served:	2/12/03
Hearing Dates:	2/24, 2/25/03
Date of Deliberations:	2/25, 4/1/03

STATEMENT OF CHARGES

The Statement of Charges (Petitioner's Exhibit 1 [hereinafter referred to as "Pet. Ex."]) alleged four specifications of professional misconduct, including gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion. The charges pertain to Respondent's treatment of Patient A.

FINDINGS OF FACT

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

Having heard testimony and considered evidence presented by the Petitioner and

Respondent respectively, the Committee hereby makes the following Findings of Fact;

1. The Respondent, Richard Dale Semeran, M.D., was authorized to practice medicine in New York State on November 19, 1987 by the issuance of license number 173039 by the New York State Education Department, and is currently registered with the New York State Education Department to practice medicine in New York State (Pet. Ex. 1-not contested).
2. Upon completion of his residency, beginning in 1987, Respondent entered into a five year contract of employment as a physician with the Obstetrical & Gynecological Care Associates of Syracuse (T. 159-160).
3. On November 29, 1989, Respondent provided medical care to Patient A who had been referred by Thomas LaClaire, M.D. Patient A presented with a history of polymenorrhea and irregular bleeding which was not controlled with progesterone therapy. Polymenorrhea is a condition where menstrual periods occur too frequently (Pet. Ex. 3, pg. 1, 15-16 and Ex.6, pg. 100-103; T. 38-41; Resp. Ex. D).
4. Respondent obtained a history for Patient A which included, among other things, a chief complaint of irregular menses and notations that Patient A's last menstrual period was on November 17, 1989, that she was not using birth control and that she was negative for the pregnancy hormone, human chorionic gonadotropin {"hCG"} according to Dr. LaClaire's office (Pet's Ex. 3, pg.1; T. 41-42, 44, 194, also 62 re definition of hCG).
5. Patient A also submitted a four page patient data sheet on which she responded to numerous questions concerning her medical history and attached a chronological listing of the dates of her irregular bleeding, all of which became

part of her medical record (Pet's Ex. 3, pg.15-19; T. 41-44).

6. Patient A indicated on the patient data sheet her most recent normal period occurred on September 18 through September 23, 1989 and that her periods generally lasted for five days. Her last 5 day cycle had occurred on September 18 through September 23, 1989 (Pet. Ex.3, pg. 15-16; T. 202).
7. Patient A also indicated on the patient data sheet that she was sexually active (Pet. Ex.3, pg. 17).
8. Respondent did not record the date of Patient A's most recent negative pregnancy test, including the date on which the negative hCG result was obtained by Dr. LaClair (Pet. Ex. 3).
9. The record of Patient A's history did not deviate from accepted standards of medical care (T. 311-312).
10. Respondent conducted a physical examination of Patient A including a pelvic examination (Pet. Ex. 3, pg. 1; T. 44-45).
11. Respondent noted that Patient A's cervix was parous (i.e.- having been stretched by a previous delivery), and described her uterus as "slightly enlarged, 4 to 6 weeks size, smooth" (Pet. Ex. 3, pg. 1; T.45).
12. Respondent recorded an impression of dysfunctional uterine bleeding ("DUB"), rule out myomata/adenomyosis. Myomata are fibroid tumors within or on the surface of the uterus (Pet. Ex. 3, pg. 1; T. 46).
13. Respondent ordered laboratory studies of Patient A's LH and FSH levels. LH and FSH are substances produced by the pituitary gland which stimulate the ovary to produce hormones and either ovulate or not depending on the cycle of production. A disparity between LH and FSH could be an indication of

polycystic ovarian disease which could cause irregular periods and dysfunctional bleeding (T. 48-50; Pet. Ex. 3, pg. 1).

14. Respondent did not record any explanation as to why he was ordering LH and FSH studies. This omission did not constitute a deviation from the standard of care (Pet. Ex. 3 ; T. 49, 312-313).
15. Respondent did not cause a pregnancy test to be performed on Patient A on November 29, 1989 or otherwise order a pregnancy test. These omissions on November 29, 1989 did not constitute a deviation from the standard of care (Pet. Ex. 3; T. 172-175, 315-317).
16. Respondent scheduled Patient A for an examination under anesthesia ("EUA"), a hysteroscopy and a fractional dilation and curettage ("D & C"). A hysteroscopy is a procedure in which an instrument is utilized to visualize the inside of the uterine cavity to determine if any abnormalities are present. A fractional D & C involves dilating the cervix and curetting or scraping the lining of the cervix in order to obtain a tissue sample (Pet. Ex.3, pg. 1; T. 73-74).
17. Respondent's care of Patient A on November 29, 1989 did not deviate from the standard of care (T. 317).
18. Patient A was admitted for a planned examination under anesthesia, hysteroscopy and D & C at Community General Hospital of Greater Syracuse ("Community General Hospital"), on January 19, 1990 (Pet. Ex. 4, pg. 1; Resp. Ex. D).
19. Respondent did not order a pregnancy test or ultrasound between the time of Patient A's November 29, 1989 office visit and her hospital admission nor did he see Patient A during that time period (T. 74-75, 174-176).

20. Respondent's decision not to do an ultrasound was a matter of clinical judgement and not a deviation from acceptable medical standards (Pet. Ex. 3; T. 71-72, 75-76).
21. Respondent, between Patient A's November 29, 1989 office visit and her hospital admission, did not take an interval history from Patient A in his office or perform a pelvic examination upon her in his office (Pet. Ex. 3; T. 75-76, 273-274).
22. It was not a deviation from the standard of care for Respondent not to schedule an office visit with Patient A or otherwise examine Patient A during the interval between Patient A's November 29, 1989 office visit and her January 19, 1990 hospital admission (T. 77).
23. The LH study, ordered on November 29, 1989, indicated that Patient A's LH level was 111 which is an elevated LH level (Pet. Ex. 3, pg. 13 and Ex. 4, pg. 5; T. 59-62).
24. LH will generally surge 24 hours prior to ovulation. An elevated LH level may suggest the presence of the pregnancy hormone, hCG (T. 59-63; Pet's Ex. 8).
25. Although Respondent recorded in Patient A's hospital chart that her LH level was elevated at 111, Respondent did not record any explanation or record any attempt to investigate why Patient A's LH level was elevated. This was not a deviation from the standard of care (Pet. Ex. 3 and Ex. 4, pg. 5; T. 52, 65-66).
26. Respondent noted that Patient A's last normal menstrual period was in September 1989 but that she continued to have vaginal bleeding 2-3 times a month. Patient A's hospital chart history did not address the possibility of pregnancy (Pet. Ex. 4, pg. 5).

27. Respondent performed a pelvic examination on Patient A at Community General Hospital prior to her surgery and noted that her uterus was enlarged to at least symphysis. Symphysis is consistent with a uterus that is twelve weeks size (Pet. Ex.4, pg. 5; T. 81-82).
28. Respondent's operative note states that upon examination under anesthesia, Patient A's uterus was enlarged to approximately 10-12 weeks size, consistent with her office examination. Patient A's uterus was recorded as being 4-6 weeks size during the office visit. Respondent's operative note shows no recognition of the discrepancy in the size of Patient A's uterus (Pet. Ex. 3, pg. 1 and Ex. 4, pg. 6).
29. Fibroid tumors are generally slow growing. It would have been unlikely that a fibroid tumor would have grown from four to six weeks uterine size on November 29, 1989 to 10-12 weeks size by January 19, 1990 in the absence of bleeding into the fibroid or degeneration of the fibroid (T.47, 84).
30. Respondent did not order a pregnancy test prior to beginning surgery upon Patient A. This was the sentinel deviation from the standard of care (T. 184-185, 200, 325-326).
31. Respondent, following the examination under anesthesia, proceeded to insert a hysteroscope into Patient A's cervix. Respondent was unable to visualize the uterus adequately and the procedure was abandoned (Pet. Ex. 3, pg. 3 and Ex. 4, pg. 6).
32. Respondent failed to consider a diagnosis of pregnancy when he was unable to adequately visualize Patient A's uterine cavity (T. 185).
33. Respondent then sounded Patient A's uterus to a depth of approximately 8.5 to

9 cms. (Pet. Ex. 3, pg. 3-4 and Ex. 4, pg. 6, 21).

34. Upon dilating the cervix and attempting to insert a small endometrial curette, the curette was inhibited by an apparent mass or structure. A small curette generally slips easily into the uterine cavity (Pet. Ex. 3, pg. 3-4 and Ex. 4, pg. 6, 21; T. 87).
35. Respondent, then, curetted a small amount of anterior wall endometrium and noted that active bright red bleeding was occurring at approximately 30-40 cc's (Pet. Ex. 3, pg. 3-4 and Ex. 4, pg. 6, 21).
36. If a patient was pregnant at the time of a hysteroscopy or a fractional D & C, performing such procedures would place the pregnancy at risk. A pregnancy is attached to the lining of the uterus and occupies the cavity of the uterus. Any procedure that would disrupt the lining of the uterus in terms of trying to obtain a tissue specimen would in all likelihood disrupt the implantation of the pregnancy that is attached to the lining of the uterus and cause a loss of the pregnancy (T. 74).
37. Respondent failed to consider a diagnosis of pregnancy when he accomplished the curettage (T. 185).
38. Respondent then terminated the procedure and packed Patient A's vagina with 4 X 4 vaginal packs (Pet. Ex.4, pg. 8, 16, 21).
39. Patient A was discharged and sent home that day. Her written discharge instructions were to call Respondent's office within one week for an appointment in four weeks. Respondent signed out Patient A's medical record face sheet on January 19, 1990 with diagnoses of dysfunctional uterine bleeding refractory to hormonal therapy and myomatous uterus (Pet. Ex. 4, pg. 1 and 4; T. 244).

40. On January 24, 1990, at approximately 11:30 p.m., Patient A presented to the emergency room at Community General Hospital with a pulseless umbilical cord protruding from her vagina (Pet. Ex. 5, pg. 3,6).
41. Patient A delivered a stillborn male fetus . Pathological examination revealed a fetus of approximately 18-19 weeks gestation, by length and weight (Pet. Ex. 3, pg. 8 and Ex. 5, pg. 6, 17; T.96-98).
42. It was a deviation from accepted standards of care, on January 19, 1990, for Respondent to fail to consider the possibility that Patient A was pregnant and to fail to order a pregnancy test prior to surgery, and then perform a hysteroscopy and fractional D & C which risked the loss of Patient A's pregnancy. (Pet. Ex. 3, pg. 3-4 and Ex. 4, pg. 6, 21; T. 79-81, 112-114, 149-150).
43. The dilation and curettage resulted in the loss of Patient A's pregnancy (T. 144-145).
44. Respondent dictated his operative report on February 21, 1990 and it was transcribed on February 28, 1990. The report makes no mention of Patient A's failed pregnancy (Pet. Ex. 4, pg. 6, 21).

CONCLUSIONS OF LAW

Respondent is charged with four 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 Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct

Under the New York State Education Law " sets forth suggested definitions for negligence, gross negligence, gross incompetence and incompetence and was provided to the Respondent through his attorney at a pre-hearing conference held on February 12, 2003 (Transcript of pre-hearing conference, pg. 32).

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances, Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding. (Id.). The statutory definition of "negligence" for professional misconduct purposes contained in N.Y. Educ. Law §6530(3) requires proof of negligence "on more than one occasion". The Court of Appeals has interpreted "occasion" to mean "an event of some duration, occurring at a particular time and place, and not simply a discrete act of negligence which can occur in an instant" Rho v. Ambach, 74 N.Y.2d 318, 322 , 546 N.Y.S. 2d 1005 (1989) ("Rho"). While several acts of negligence occurring during a single autopsy do not constitute professional misconduct (Rho), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct, Orosco v. Sobol, 162 A.D. 2d 834, 557 N.Y.S. 2d 738 (3d Dept. 1990).

Gross negligence may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." (Rho, supra at 322). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion (Rho, supra at 322). No single formula has been articulated to differentiate between simple negligence and errors that are

viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad", 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 significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient Post v. State of New York Department of Health, 245 A.D. 2d 985, 986, 667 N.Y.S. 2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct, Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752, 634 N.Y.S. 2d 856 (3d Dept. 1995).

Incompetence is the lack of requisite skill or knowledge to practice medicine safely Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with incompetence "on more than one occasion". "On more than one occasion" carries the same meaning it does in relation to negligence on more than one occasion as set forth above.

Gross incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences, Post, Supra at 986.

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

The Committee viewed this case as one in which the medical records spoke for themselves. While the expert testimony was of some usefulness in terms of defining the standard of care, the medical records themselves basically compelled the Committee to

reach its decision in this case.

The Committee considered the credibility of the various witnesses and thus the weight to be accorded to their testimony. Both Dr. Tatelbaum who testified as an expert on behalf of the Department, and Dr. Uva who testified as an expert on behalf of the Respondent, were regarded as strongly credible and very straightforward. However, as indicated above, the expert testimony merely confirmed for the Committee what was obvious from the medical records.

Respondent testified on his own behalf. The Committee did not find Respondent entirely credible and believed that while he admitted to missing Patient A's pregnancy on the January 19, 1990 hospital admission, he still attempted to evade responsibility in his testimony. For example, Respondent attributed much of the fault for the missed pregnancy to the office procedures of his medical group, Obstetrical & Gynecological Care Associates of Syracuse, rather than squarely accepting responsibility.

The Committee noted that Respondent did not dictate his operative report until February 21, 1990 and questioned the credibility of the report in light of Patient A's delivery of a still born pregnancy on January 24, 1990. The Committee also questioned Respondent's motivation for completing and signing Patient A's face sheet on January 19, 1990, the day of Patient A's procedure, with diagnoses of dysfunctional uterine bleeding refractory to hormonal therapy and myomatous uterus. At that time, Respondent had not yet completed his operative report or seen a pathology report.

Although the Committee did not find Respondent entirely credible, it did not conclude that Respondent's notation of "- hCG- La Claire" on Patient A's November 29, 1989 history (Pet. Ex. 3, pg. 1) was inaccurate.

The Committee reaches the following Conclusions with regard to the Factual

Allegations set forth in the Statement of Charges (Pet. Ex. 1). Preliminarily, the Committee notes that the Factual Allegations contained in Paragraphs A, B and C were admitted to by Respondent in his Exhibit D, and were supported by the evidence, as well. The Committee sustains those Factual Allegations. Additionally;

Factual Allegations A.2, A.3, A.4 and A.5 are sustained.

Factual Allegation A.1 is not sustained.

Factual Allegation A.1 is not sustained. Given the circumstances of Patient A's first visit to Respondent on November 29, 1989, Respondent's medical history of Patient A on that date complied with accepted standards of medical care. The history included, among other things, a chief complaint of irregular menses and notations that Patient A was not using birth control and that she was negative for the pregnancy hormone, hCG, according to Dr. LaClaire's office. Patient A's office record also included a four page patient data sheet on which Patient A responded to numerous questions concerning her medical history and attached a chronological listing of the dates of her irregular bleeding. The Committee views the history as being comprehensive.

Although as indicated below, the Committee concludes that Respondent did not document the date of Patient A's most recent negative pregnancy test, the Committee did not sustain Factual Allegation A.1. Respondent's omission of a date did not render Patient A's history inadequate. With the benefit of hindsight, it may appear that this omission was significant. However, the Committee did not believe that Respondent's omission of a date, in and of itself, caused Patient A's history to be inadequate. This was Respondent's first encounter with Patient A. Respondent may have been diverted from a diagnosis of pregnancy by Patient A's history of irregular bleeding.

With regard to Factual Allegation A.2, the Committee concludes that Respondent, on

the November 29, 1989 visit, did not note the date of Patient A's most recent negative pregnancy test or order a pregnancy test and sustains the allegation on the facts.

The Committee concludes that there was an absence of any documentation in Pet. Ex. 3 as to the reasons why Respondent ordered Patient A's FSH and LH levels to be analyzed (Factual Allegation A.3). Respondent did not follow up on January 19, 1990 when the results of the LH test disclosed that Patient A had an elevated LH level of 111 (Factual Allegation A.4). The Committee also concludes that Respondent failed to appropriately manage Patient A preoperatively by obtaining a pregnancy test or ultrasound prior to the planned hysteroscopy and D & C on January 19, 1990 (Factual Allegation A.5). These Factual Allegations are, therefore, sustained.

Although Factual Allegations A.2, A.3 and A.4 are upheld as being factually accurate, the Committee concludes that none of these allegations form a basis for supporting any of the specifications. With the benefit of hindsight, it may appear that criticism of Respondent's actions on the November 29, 1989 visit is warranted. However, given the information available to Respondent on that initial visit, his care of Patient A on November 29 did not rise to the level of a deviation from acceptable medical standards. With regard to Factual Allegation A.2, Respondent was seeing Patient A for the first time and may have been misled by her history of irregular bleeding and the reported negative hCG result. Similarly, with regard to Factual Allegations A.3 and A.4, Respondent's failure on November 29 to record reasons for ordering FSH and LH levels or to, thereafter, follow up on the results, does not rise to the level of a deviation from the standard of care.

The Committee was greatly concerned as to Respondent's actions on January 19, 1990 when the hysteroscopy and D & C were performed. Given that Respondent noted on

that date that Patient A's last normal period was in September of 1989, it was inexcusable that Respondent failed to have Patient A undergo a pregnancy test prior to subjecting her to procedures which had the potential to disrupt a pregnancy. While it would have been desirable to obtain a pregnancy result at some point between the November 29, 1989 visit and the January 19, 1990 procedures, the critical and final point at which such a test needed to be done was on January 19, 1990 prior to the hysteroscopy and D & C.

The Committee, therefore, sustains Factual Allegation A.5 as negligence only to the extent that Respondent failed to appropriately manage Patient A preoperatively on January 19, 1990 by ordering a pregnancy test.

Factual Allegations B.1, B.2, and B.3 are sustained.

With respect to Factual Allegation B.1, Respondent did not see Patient A after November 29, 1989 until he saw her preoperatively at Community General Hospital on January 19, 1989. After November 29, 1989, Respondent never took an interval history from Patient A in his office and failed to perform a pelvic examination on her in his office prior to the January 19, 1989 hospital admission. In the history taken at the hospital on January 19, 1990, Respondent never addressed the possibility of pregnancy other than to record that her last menstrual period was in September of 1989. B.1 is thus sustained as being factually accurate.

Respondent's operative note and actions demonstrate that Respondent did not recognize or evaluate the discrepancy between his findings as to the size of Patient A's uterus at the time of the November 29, 1989 office visit (4 to 6 weeks size) and his examination of Patient A under anesthesia (10 to 12 weeks). In fact, Respondent's operative note states that the findings under anesthesia were consistent with those findings made at the office (Factual Allegation B.2). Factual allegation B.2 is sustained as true.

Despite the discrepancy and the interval since the November 29, 1989 visit, Respondent did not order a pregnancy test prior to surgery. Factual Allegation B.3 is sustained as true.

The Committee sustains Factual Allegations B.2 and B.3 as negligence to the extent that they relate to Respondent's actions on January 19, 1990.

The Committee does not sustain Factual Allegation B.1 as negligence. While it would have been desirable for an interval history to have been taken in Respondent's office and for a pelvic examination to have been performed in Respondent's office in the interval prior to surgery, these omissions do not rise to the level of deviations from the standard of care. The critical omission by Respondent was his failure to cause a pregnancy test to be performed on Patient A on the date of surgery, January 19, 1990.

It appears from the January 19, 1990 history that Respondent was aware prior to surgery that Patient A's last period had in been in September of 1989. This information should have alerted Respondent that he needed to obtain a pregnancy test for Patient A. The fault was not in the history but in Respondent's perception of the information obtained.

Factual Allegations C.1, C.2 and C.3 are sustained.

With respect to Factual Allegations C.1, C.2 and C.3, Respondent's operative note and testimony demonstrate that having failed to diagnose Patient A's pregnancy preoperatively or intraoperatively, he failed to consider a diagnosis of pregnancy when he was unable to adequately visualize Patient A's uterine cavity (Factual Allegation C.1), when entry of a small curette into Patient A's uterine cavity was inhibited (Factual Allegation C.2) and when he performed a D & C upon Patient A. The D & C ultimately resulted in the unintended loss of Patient A's pregnancy (Factual Allegation C.3).

First Specification – Gross Negligence is sustained as to Factual Allegations A, A.5, B, B.2, B.3, C, C.1, C.2 and C.3.

By a 2 to 1 vote, the Committee sustains the specification of gross negligence insofar as Factual Allegations A, A.5, B, B.2, B.3, C, C.1, C.2 and C.3 relate to Respondent's actions or omissions on January 19, 1990. The Committee views those acts or omissions of Respondent which occurred prior to January 19, 1990 as not rising to the level of negligence.

Two Committee members conclude that Respondent's performance of surgery on Patient A on January 19, 1990 without a prior pregnancy test constituted an act of negligence of egregious proportions. They viewed that Respondent's conduct risked grave consequences in light of the possibility that Patient A might have been pregnant and that the procedures performed risked the loss of Patient A's pregnancy. This risk was borne out by the loss of pregnancy which did in fact occur. In light of the egregious nature of Respondent's conduct, the specification of gross negligence is sustained, by a two to one vote.

One Committee member did not view Respondent's conduct as being grossly negligent. The conduct was not seen as being grossly negligent by virtue either of the result (the loss of the pregnancy) or by Respondent's omission which essentially consisted of a lapse of clinical judgement in failing to recognize Patient A's pregnancy. All other actions of Respondent were viewed as being consistent with sound medical standards considering Respondent's working diagnosis.

Second Specification-Negligence on More than One Occasion Not Sustained

The Second Specification of negligence on more than one occasion is not

sustained. The Committee concludes that the negligence occurred on the one occasion of January 19, 1990 and that, in any event, the negligence was attributable to a single act or omission which deviated from acceptable medical standards. This omission consisted of Respondent's failure to recognize that Patient A might be pregnant prior to and at the time he was unable to adequately visualize the uterine cavity (Factual Allegation C.1), when entry of a small curette was inhibited (Factual Allegation C.2) and when he performed a D & C upon Patient A (Factual Allegation C.3). In the Committee's judgment, this constitutes a single act of negligence.

The actions committed by Respondent as a result of his single act of negligence can be broken down to include many of the Factual Allegations sustained by the Committee. However, these actions would not have individually constituted a deviation from acceptable medical standards were it not for Respondent's failure to recognize and investigate whether Patient A was pregnant.

Respondent saw Patient A on two occasions, November 29, 1989 and January 19, 1990. The record of the November 29 encounter which was an initial patient visit, conformed to the expected standard of care. While Respondent, on November 29, did not entertain a diagnosis of current pregnancy, a misdiagnosis on an initial visit is common enough such that Respondent's actions on that date did not fall beneath the expected standard of care. Had Patient A not been pregnant, the November 29 visit would without question have been considered a reasonable initial patient encounter and Respondent's plan of care would have been considered reasonable as well.

At the January encounter, Respondent was obliged to ascertain that Patient A was not pregnant before subjecting her to an invasive procedure of the uterus. This was the sole negligent act on Respondent's part.

The Committee observes that there are many ways for an obstetrician to ascertain whether a patient is pregnant. The Department proved that Respondent failed in a number of ways to diagnose Patient A's pregnancy, as enumerated in the Factual Allegations. The Committee, nevertheless, concludes that however many avenues there may be to diagnose pregnancy, Respondent's failure to diagnose Patient A's pregnancy constitutes a single act of a failure to diagnose.

The Committee unanimously agrees that Respondent's failure to diagnose Patient A's pregnancy constitutes nothing more than a single act of negligence on a single occasion and disagrees that this failure constitutes multiple acts of negligence.

Third Specification- Gross Incompetence Not Sustained

The Third Specification of Gross Incompetence is not sustained. The Committee concludes that Respondent's conduct did not demonstrate such a serious lack of the requisite skill or knowledge to practice medicine safely that Respondent would be guilty of gross incompetence.

Fourth Specification- Incompetence on More than One Occasion Not Sustained

The Fourth Specification of Incompetence on More than One Occasion is not sustained. The Committee felt that Respondent, having failed to diagnose Patient A's pregnancy either preoperatively or intraoperatively, failed to consider a diagnosis of pregnancy when he was unable to adequately visualize the uterine cavity (Factual Allegation C.1), when entry of a small curette was inhibited (Factual Allegation C.2) and when he performed a D & C upon Patient A (Factual Allegation C.3), and thereby demonstrated incompetence at the time of surgery on January 19, 1990. The Committee believes that only a single occasion or act of incompetence was involved in this transaction,

i.e.- Respondent's failure to recognize the possibility that Patient A was pregnant prior to performing the acts described in Factual Allegations C.1, C.2 and C.3. The specification is not sustained.

PENALTY

Pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above and taking all of the facts, details, circumstances and particulars in this matter into consideration, the Committee unanimously determines that the following resolution is the appropriate action under the circumstances.

The Committee imposes no penalty upon Respondent. Public Health Law § 230-a lists penalties which may be imposed for professional misconduct. There is no requirement that a penalty be imposed in all circumstances of misconduct. The determination to impose no penalty 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.

In this case, Respondent's misconduct dates back to early 1990. Nothing was presented which would lead the Committee to believe that since January of 1990, Respondent has either repeated the misconduct which was the subject of this proceeding or has engaged in other types of medical misconduct. Additionally, Respondent's testimony demonstrated that he understood his mistake. Consequently, the Committee is of the opinion that Respondent has learned from this experience and is not apt to repeat it. While the Committee sustained the Specification of gross negligence, the Committee views Respondent's omission to be one of clinical judgement and does not feel that the imposition of any of the penalties set forth in Public Health Law § 230-a are necessary in this instance to further the public safety.

All other issues raised by both parties have been duly considered by the Committee and would not justify a change in the Findings, Conclusions, Penalty or Determination contained herein

By execution of this Determination and Order, all members of the Committee certify that they have considered the complete evidentiary record of this proceeding, including all exhibits and testimony.

ORDER

IT IS HEREBY ORDERED THAT:

1. The First Specification of professional misconduct is **SUSTAINED**;
2. The remaining Specifications are **DISMISSED**;
3. **NO PENALTY** is imposed against Respondent; and
3. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Pittsford, New York
23 May, 2003


CHARLES J. VACANTI, M.D.
Chairperson

LEMUEL ROGERS, M.D.
WILLIAM WALENCE, PhD

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APPENDIX 1

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

IN THE MATTER
OF
RICHARD DALE SEMERAN, M.D.

STATEMENT
OF
CHARGES

RICHARD DALE SEMERAN, M.D., Respondent, was authorized to practice medicine in New York State on November 19, 1987, by the issuance of license number 173039 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine in New York State.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care to Patient A (identified in Appendix) on or about November 29, 1989, at the offices of Obstetrical and Gynecological Care of Syracuse, P.C., 600 East Genesee Street, Syracuse, New York 13202, the practice with which Respondent was associated at that time. Patient A presented with a history of polymenorrhea and irregular bleeding which was not controlled with progesterone therapy. Respondent's recorded impression was "DUB (dysfunctional uterine bleeding), rule out myomata/adenomyosis." Respondent's recorded plan of treatment was to schedule Patient A for an evaluation under anesthesia, hysteroscopy and a fractional D&C. Respondent's care of Patient A failed to meet accepted standards, in that:

1. Respondent failed to obtain an adequate history for Patient A.
 2. Respondent failed to ascertain the date of Patient A's most recent negative pregnancy test and/or to order a pregnancy test.
 3. Respondent failed to document why he ordered FSH and LH levels for Patient A.
 4. Respondent, despite the fact that the LH (luteinizing hormone) level he had ordered on November 29, 1989 was elevated, failed to adequately investigate and/or explain the patient's elevated LH level prior to surgery.
 5. Respondent failed to appropriately manage Patient A preoperatively prior to the planned hysteroscopy and D & C.
- B. On or about January 19, 1990, Patient A was admitted to Community General Hospital in Syracuse, New York for a planned examination under anesthesia, hysteroscopy and D&C to be performed by Respondent. Respondent's care of Patient A failed to meet accepted standards, in that:
1. Respondent, despite the interval between Patient A's November 29, 1989 office visit and the January 19, 1990 surgery, failed to take an adequate interval history from Patient A in his office prior to admission or in the hospital prior to surgery and/or failed to perform a pelvic examination on Patient A in his office prior to admission.

2. Respondent failed to appropriately recognize and/or adequately evaluate the discrepancy between his findings as to the size of Patient A's uterus at the November 29, 1989 office visit (4 to 6 week size) and Respondent's January 19, 1990 examination under anesthesia of Patient A (10 to 12 week size).
 3. Respondent, despite the interval between Patient A's November 29, 1989 office visit and the January 19, 1990 surgery, and/or despite the change in uterine size during this interval, failed to order a pregnancy test prior to surgery.
- C. Respondent, on or about January 19, 1990, at Community General Hospital in Syracuse, New York, attempted to perform a hysteroscopy and D&C on Patient A.
1. Respondent, having failed to diagnose Patient A's pregnancy preoperatively and/or intraoperatively, failed to consider a diagnosis of pregnancy when he was unable to adequately visualize the uterine cavity.
 2. Respondent, having failed to diagnose Patient A's pregnancy preoperatively and/or intraoperatively, failed to consider a diagnosis of pregnancy when entry of a small curette was inhibited.
 3. Respondent, having failed to diagnose Patient A's pregnancy preoperatively and/or intraoperatively, performed a D & C which resulted in an unintended loss of the pregnancy.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5; and/or B and B.1 and/or B.2 and/or B.3; and/or C and C.1 and/or C.2 and/or C.3.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5; and/or B and B.1 and/or B.2 and/or B.3; and/or C and C.1 and/or C.2 and/or C.3.

THIRD SPECIFICATION
GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

3. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5; and/or B and B.1 and/or B.2 and/or B.3; and/or C and C.1 and/or C.2 and/or C.3.

FOURTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges that Respondent committed two or more of the following:

4. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5; and/or B and B.1 and/or B.2 and/or B.3; and/or C and C.1 and/or C.2 and/or C.3.

DATED: January 16, 2003
Albany, New York


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