

# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower      The Governor Nelson A. Rockefeller Empire State Plaza      Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.  
*Commissioner*

Karen Schimke  
*Executive Deputy Commissioner*

July 11, 1996

## **CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Kevin C. Roe, Esq.,  
Associate Counsel,  
NYS Department of Health  
Bureau of Professional Medical Conduct  
Corning Tower Building, Room 2429  
Empire State Plaza  
Albany, New York 12237-0032

Meera Chaudhuri, M.D.,  
460-B Canisteo Street  
Hornell, NY 14843

BOND, SCHOENECK & KING, LLP,  
Thomas E. Myers, Esq., of counsel.  
One Lincoln Center  
Syracuse, NY 13202

Effective Date: 07/18/96

### **RE: In the Matter of Meera Chaudhuri, M.D.**

Dear Mr. Roe, Dr. Chaudhuri and Mr. Myers:

Enclosed please find the Determination and Order (No.96-72) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

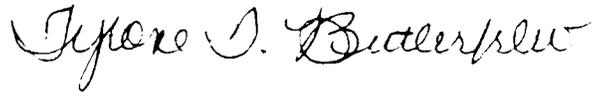
Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct  
New York State Department of Health  
Empire State Plaza  
Corning Tower, Room 438  
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above

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

Sincerely,

A handwritten signature in black ink that reads "Tyrone T. Butler". The signature is written in a cursive style with a large, stylized initial 'T'.

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB rlw

Enclosure

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

COPY

-----X  
                  IN THE MATTER                  :  
  :  
  :  
  :  
  :  
  :  
  :  
                  MEERA CHAUDHURI, M.D.          :  
-----X

ADMINISTRATIVE  
REVIEW BOARD  
DECISION AND  
ORDER NUMBER  
ARB# 96-72

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of SUMNER SHAPIRO, ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD SINNOTT, M.D., and WILLIAM A. STEWART, M.D. held deliberations on June 7, 1996 to review the Hearing Committee on Professional Medical Conduct's (hereinafter the "Hearing Committee") March 29, 1996 Determination finding Dr. Chaudhuri guilty of professional misconduct. The Respondent requested a Review through a Notice which the Board received on April 8, 1996. The Petitioner also requested a Review through a Notice which the Board received on April 12, 1996. Larry G. Storch served as Administrative Officer to the Review Board. Thomas E. Myers, Esq. filed a brief for the Respondent which the Review Board received on May 29, 1996. Kevin C. Roe, Esq. filed a brief for the Petitioner which the Review Board received on May 15, 1996.

### SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

### HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with ten specifications of professional misconduct, including allegations of gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion. These allegations concern the Respondent's medical care and treatment of four patients.

The Hearing Committee sustained two specifications of professional misconduct, based upon a determination that the Respondent was guilty of negligence on more than one occasion and

incompetence on more than one occasion, with regard to each of the four named patients. The Hearing Committee dismissed all specifications of gross negligence and gross incompetence.

Patient A

The Hearing Committee found that Respondent treated Patient A, a 17 year-old female approximately four and one-half months into her first pregnancy. Patient A presented at the emergency room at St. James Mercy Hospital (St. James) in Hornell, New York, with complaints of vaginal bleeding 20 minutes prior to coming to St. James, with heavy bleeding for one day, and spotting. The patient reported lower left abdominal pain without cramps and had no fever or chills, nausea, vomiting or diarrhea. The patient was examined in the emergency room by another physician, who found a soft abdomen, no CVA tenderness, no blood, stable vital signs, and the cervix was stated to be friable with a small opening. At 5:10 p.m. the physician contacted the Respondent by telephone.

The Hearing Committee further found that the Respondent gave a telephone order for the administration of intravenous Pitocin to run at 150 cc's per hour. At 6:50 p.m., the Respondent examined the patient and found no significant bleeding, a closed cervix and a fetal heart rate of 140-150. She then discontinued the Pitocin.

The Hearing Committee concluded that there was nothing in the patient's medical records which would indicate that Patient A was not stable, and that no emergency situation existed which required immediate drug intervention. The Hearing

Committee further concluded that the Respondent's medical care and treatment of this patient demonstrated both negligence and incompetence.

#### Patient B

The Hearing Committee found that the Respondent admitted Patient B, a 34 year-old female, to St. James for elective surgery intended to address complaints of pelvic pressure, excessive menstrual bleeding and urinary incontinence. Patient B had a previous history of ulcerative colitis for which she was taking Prednisone. The Committee further found that the patient gave conflicting information to the Respondent and other physicians concerning her compliance with the Prednisone regime. The Hearing Committee concluded that the Respondent failed to properly evaluate whether the patient needed pre-operative steroid coverage, and sustained charges of negligence and incompetence regarding this patient.

#### Patient C

The Hearing Committee further found that the Respondent admitted Patient C, a 56 year-old female, to St. James on October 7, 1992 for a non-emergency surgical removal of her uterus, repair of the cystocele and rectocele and possible removal of fallopian tubes and ovaries. Patient C's history, as recorded by Respondent, included smoking one pack of cigarettes a day for 40 years, chronic obstructive pulmonary disease, pneumonia, bronchitis, emphysema and smoker's cough. As part of a pre-operative work-up, chest x-rays were taken. The conclusion of the radiology report was "right middle lobe collapse with

possible infiltrate". (See, Pet. Exh. #4, p. 137).

The Hearing Committee further found that the Respondent's report of Patient C's history and physical noted that Dr. Rao, the anesthesiologist, examined the patient's chest and found it to be within normal limits. On October 7, 1992, Patient C underwent non-emergency surgery, as scheduled. The patient's medical record does not include any reference to any other evaluation of the x-rays other than the original radiology report.

The Hearing Committee concluded that the respondent failed to either obtain a consult, or to document in the record that the radiology report was in error. The Committee found no clear evidence of logical thinking by the Respondent in addressing the radiology report prior to and after the surgery. The Committee sustained charges of negligence and incompetence with regard to this patient.

#### Patient D

The Hearing Committee found that the Respondent treated Patient D, a 31 year-old female over a five year period. The Committee further found that the Respondent performed a D & C<sup>1</sup> and cone biopsy of the cervix on December 11, 1990. After being anesthetized for surgery, the Respondent examined the patient's uterus and found it to be enlarged comparable to a 6 week gestation. The Respondent made no further evaluation regarding the possibility of pregnancy and proceeded with the scheduled

---

<sup>1</sup>Dilatation and curettage

surgery.

The Hearing Committee concluded that the Respondent failed to obtain adequate menstrual and contraceptive histories prior to Patient D's surgery, failed to ascertain whether the patient was pregnant prior to the surgery, and failed to delay or discontinue the surgery to allow the patient the opportunity to evaluate the possibility of a pregnancy. The Committee concluded that the Respondent's conduct with regard to Patient D constituted negligence and incompetence.

The Committee voted to suspend the Respondent's license to practice medicine in New York State for one (1) year. The suspension was stayed and the Respondent was placed on probation for a period of three (3) years. Included in the terms of probation are a requirement of monthly monitoring of the Respondent's practice by a board certified OB/GYN in current and active practice, as well as random chart reviews (hospital and office) of no fewer than ten histories per month.

The Hearing Committee considered revocation of the Respondent's medical license but determined that Respondent is capable of providing medically acceptable care and treatment. The Committee placed greater weight on the information and straightforward admissions that the Respondent provided to the Department's investigator, than on her testimony at the hearing. These observations were proper, insightful, and gave indications of Respondent's ability to ask for help when needed. They noted that when the Respondent is overly busy, she seems to get sloppy or less careful and pays insufficient attention to details.

Accordingly, the Committee determined that a three year period of probation, with a practice monitor, will help the Respondent as well as adequately protect the public. The Hearing Committee also placed weight on the fact that the Respondent has attended CME training at an average rate of approximately 100 CME hours annually.

#### REQUEST FOR REVIEW

**PETITIONER:** On his appeal, the Petitioner argues that the penalty imposed by the Hearing Committee is not appropriate. The Petitioner argues that the Respondent failed to take responsibility for her deficiencies and testified falsely under oath, in an attempt to subvert the disciplinary process and avoid responsibility for her actions. The Petitioner further argues that the Respondent repeatedly demonstrated her lack of knowledge and understanding regarding basic medical principles essential to minimally acceptable standards of care. Consequently, the Petitioner argues that the penalty imposed by the Hearing Committee does not attempt to address the Respondent's incompetence and is therefore inadequate to protect the public health and safety. Monitoring an incompetent physician, without re-education, does not adequately protect the public.

The Petitioner urges that, should the Board find the Respondent to be a suitable candidate for rehabilitation, she should be required to enroll in, diligently pursue, and successfully complete a full-time, one-year residency/fellowship

in an American College of Graduate Medical Education - approved program, selected by the Respondent and previously approved by the Director of the Office of Professional Medical Conduct.

**RESPONDENT:** In an answering brief, the Respondent argues that the Hearing Committee's penalty is consistent with the Committee's findings of fact and conclusions of law. The Respondent further argues that the one year full-time residency requirement sought by the Petitioner is harsh, unnecessary, and should not be imposed. The Respondent argues that such a requirement would effectively bar her from practicing in the Steuben County area because it would be physically impossible to maintain her practice and attend a full-time residency or fellowship in Rochester or Syracuse. The Petitioner ignored the Respondent's strong qualifications<sup>2</sup> and her commitment to continuing medical education (CME). The Respondent has attended approximately 100 CME hours in each of the past three years.

While reserving her rights to contest the accuracy and validity of the Hearing Committee's Findings of Fact and Conclusions of Law in the appropriate appellate forum, the Respondent notes that she is willing and ready to comply with sanction imposed by the Hearing Committee. Consequently, the Respondent urges that the penalty imposed by the Hearing Committee should not be increased or made more adverse to her by the Review Board.

---

<sup>2</sup>Dr. Chaudhuri is board certified in obstetrics and gynecology by both the American College of Obstetrics & Gynecology and the Royal College of Obstetrics & Gynecology (Exh. G).

### REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes 5-0 to sustain the Hearing Committee's Determination that the Respondent was guilty of practicing with negligence on more than one occasion, and practicing with incompetence on more than one occasion. This Determination was consistent with the Committee's factual findings.

The Review Board votes 4-1 to sustain the Committee's Determination to suspend the Respondent's license to practice medicine in New York State for one (1) year, with the suspension stayed and the Respondent placed on probation for a period of three (3) years.<sup>3</sup>

The sanction recommended by the Petitioner ( a one year full- time residency/fellowship in obstetrics/gynecology) is unduly harsh and not warranted by the misconduct found by the Hearing Committee. The Review Board concurs with the detailed, thorough discussion of the sanction imposed, as set forth in the Hearing Committee's March 29, 1996 Determination and Order. The Committee analyzed the evidence and concluded that the Respondent's problems largely stemmed from haste and carelessness when busy, rather than from a fundamental lack of medical knowledge and skill. Under the circumstances, the Review Board

---

<sup>3</sup>One member of the Board voted to restrict the Respondent's license to permit practice only as a salaried employee of an Article 28 licensed facility.

agrees that a stayed suspension, with a period of probation, including a practice monitor, strikes the appropriate balance between the need to punish the Respondent and protect the public.

ORDER

NOW, based upon this Determination, the Review Board issues the following ORDER:

1. The Review Board SUSTAINS the Hearing Committee's March 29, 1996 Determination finding the Respondent guilty of professional misconduct.

2. The Review Board SUSTAINS the Hearing Committee's Determination to suspend the Respondent's license to practice medicine in New York State for one (1) year. The suspension shall be and hereby is stayed and the Respondent is placed on probation for a period of three (3) years. The complete terms of probation are contained in Appendix II of the Hearing Committee's March 29, 1996 Determination and Order and are adopted herein.

SUMNER SHAPIRO

ROBERT M. BRIBER

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

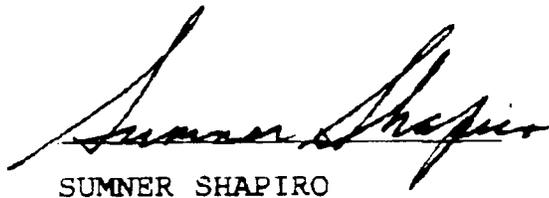
WILLIAM A. STEWART, M.D.

IN THE MATTER OF MEEERA CHAUDHURI, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chaudhuri.

DATED: Delmar, New York

July 3, 1996



SUMNER SHAPIRO

IN THE MATTER OF MEERA CHAUDHURI, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chaudhuri.

DATED: Brooklyn, New York

JUNE 28, 1996

  
WINSTON S. PRICE, M.D.

IN THE MATTER OF MEERA CHAUDHURI, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chaudhuri.

DATED: Roslyn, New York

June 28, 1996

A handwritten signature in cursive script, appearing to read "Ed C. Sinnott, M.D.", written over a horizontal line.

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF MEERA CHAUDHURI, M.D.

WILLIAM A. STEWART, M.D., a member of the  
Administrative Review Board for Professional Medical Conduct,  
*resents*  
~~consents~~ in the Determination and Order in the Matter of Dr.  
Chaudhuri.

DATED: Syracuse, New York

1 July, 1996



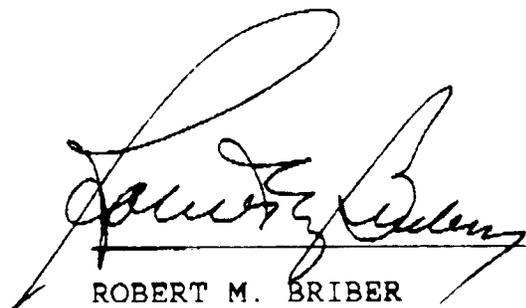
WILLIAM A. STEWART, M.D.

IN THE MATTER OF MEERA CHAUDHURI, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chaudhuri.

*Schweitzerly*  
DATED: Albany, New York

7/5/96, 1996

  
ROBERT M. BRIBER