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

IN THE MATTER

OF

JAMES R. CAPUTO, M.D.

RESPONDENT'S PROPOSED FINDINGS OF FACT AND BRIEF TO THE HEARING COMMITTEE

This brief is submitted in behalf of James Caputo, M.D., in connection with the Statement of Charges leveled against him and the proof developed in the hearing just concluded as of 8/28/07.

In the Statement of Charges seven events of patient's care were involved. The events involved three forceps assisted vaginal deliveries; one cesarian section; the medical management of a morbidly obese patient thought to be 8-9 weeks gestation who was thereafter diagnosed at 38 weeks; the medical management of a patient with tocolytic agents at 17+ weeks gestation given her subchorionic bleeding and contractions; and a patient who underwent a laparoscopic takedown of pelvic adhesions.

The State, which has the full and continuing burden of proof, produced three witnesses, Dr. Robert Tatelbaum as an expert witness, David Brittain, M.D.[1], and the spouse of patient "F".[1]

Dr. Caputo, who has no burden of proof in this administrative hearing produced eight witnesses – James R. Caputo, M.D., Steven Burkhart [2], M.D. as an expert witness in relation to patients A, B, C, and F, Ronald Stahl, M.D. as an expert witness in relation to

[1] Their testimony came via transcripts from 2005.
[2] His testimony came via transcripts from 2005.

patients D, E and F, patients A, B, and C[3], Nurse Practitioner Terri Monnett and Crouse Hospital Labor and Delivery Nurse Frances Campbell.

PRELIMINARY REMARKS

On 8/28/07 counsel for the State gave closing arguments to this hearing panel. They were grossly unfair, patently misleading and must be clarified so that this current hearing panel is not misled toward an unfair, unjust result.

At numerous times during his closing remarks (see Record at pp. 1848-1862) counsel for the State made emphatic comment on the alleged failure on the part of Dr. Caputo to have offered Patients A and C the alternative of a cesarean section. While this might well be an interesting area, it is, was and always has been wholly irrelevant to this case.

The State is limited to the allegations contained within their Statement of Charges. This is the law (Matter of Dhabuwala, 6.51 nys2d 249; Matter of Block, 73 NY2d 23). No where in the Statement of Charges is there a claim for misconduct in relation to an Informed Consent Failure. Informed Consent exists as a creature of statute pursuant to Public Heath Law § 2805-d. Were Dr. Caputo to be at risk for allegations of misconduct relative to Informed Consent, the claim would have to be outlined within the Statement of Charges, reference to Public Health Law § 2805-d cited therein, and proof offered, among other things, that the reasonably objective patient would not have undergone the procedure had the alternative been disclosed.

What the State has attempted to do, is change their claims and theories against Dr. Caputo at the conclusion of the proof. While they would have you think that it is Dr. Caputo who has altered his position by "a 180 degree change" (see Record at p 1857), in

[3] Their testimony came via transcripts from 2005.

reality the State chooses to be the ever moving, ever changing target, altering their theories at whim and turning 180 degrees whenever they see fit.

- While they have never charged Dr. Caputo with an informed consent violation, via summation they attempt to do so.
- While they saw fit to charge Dr. Caputo with a failure to properly evaluate Patient "B" for a coagulation disorder [See Exhibit "1" at factual allegation B(1)], at the time of hearing the claim was simply dropped.
- While they argued to this hearing panel that "The State is not claiming it is illegal" to use multiple operative delivery devices [vacuum extractor and forceps], they took the exact opposite position back in 2005 (See Exhibit "B" at pp. 1240-1243, 1247-1249).
- At no time in 2005 did they claim as to the 2001 case of Patient "A" that membranes were ruptured pre-maturely at increased risk of cord prolapse. This was new 2 years later (Exhibit "1" at A(1), Exhibit "B" at pp. 1120-1206).
- At no time in 2005 did they claim as to the 2001 care of Patient "A" that Pitocin use was mismanaged. This was new 2 years later (Exhibit "1" at A(1), Exhibit "B" at pp. 1120-1206).
- In 2005 as to the 2001 case of Patient "A" and also the forceps assisted delivered as to Patients "B" and "C", they claimed it was malpractice not to have an operating room with personnel present at the time efforts at forceps rotation started (i.e.: a double set-up). Two years later that claim or theory no longer exists (Exhibit "B" at pp 1153-54, 1159-60).

- In 2005 as to the 2001 case of Patient "A", they claimed that Dr. Caputo's plan was simply to rotate the fetus, remove the forceps and then allow the patient to push. Two years later that theory or claim no longer exists (Exhibit "B" at pp. 1176-1180).
- In 2005 as to the 2003 case of Patient "A", they claimed it was malpractice not to have sent the placenta to pathology. Two years later that theory on claim no longer exists (Exhibit "1", Exhibit "B" at pp.1219-1221).
- In 2005 as to the case of Patient "F", there were no claims or complaints that a pre-operative surgical consult was required or that a pre-op bowel prep was required or that the request for surgical consult upon re-admission was untimely. These were new two years later (Exhibit "B" at pp. 1281-1320).

The most troubling of transgression is the attitude of the State that Dr. Caputo has some sort of obligation to apologize to this panel and confirm that he has changed his practice decision-making, before hearing proof is complete and before said panel has deliberated. This can be found in the State summation (Record at pp 1855-56) wherein they comment upon the fact that Dr. Caputo said that he would manage these forceps cases (Patients "A, B, & C") in the same fashion today. Dr. Caputo has been informed by a fully and highly qualified reviewer, Steven Burkhart, M.D., that the care and treatment he provided to these patients did not deviate or depart from required standards of care. For the State to raise this style of argument is nothing more than their own improper effort to prejudice the Hearing Panel and the proceedings.

Marked and received into evidence at the Hearing were the following:

EXHIBIT LIST

1. Notice of Hearing, Statement of Charges, evidence of service
2. Education file as to Respondent
3. CV of Robert Tatelbaum, M.D.
4. Respondent office record for Patient A (2001 Delivery)
5. Crouse Hospital records 9/12/01-9/16/01 for Patient A (2001 Delivery)
6. Fetal monitoring strip for Patient A (2001 Delivery)
7. Fetal monitoring stip. for Patient A (2001 Delivery), annotated by Dr. Caputo

7A. Autopsy records 2001

8. Respondent Office records and Fetal monitoring strip for Patient A (2003 Delivery)
9. Crouse Hospital record 12/4/03-12/8/03 for Patient A (2003 Delivery)

9A. Crouse Hospital record 12/4/03 for Patient A's baby.

10. Sonogram for Patient A (2003 Delivery)
11. Respondent office record for Patient B.
12. Crouse Hospital Record 9/10/03- 9/15/03 for Patient B
13. Respondent office record for Patient C
14. Crouse Hospital record 8/21/03-8/23/03 for Patient C
15. Respondent office record for Patient D
16. Crouse Hospital records for D&C as to Patient D

17. Crouse Hospital record 12/7/05 – 12/9/05 for Patient D

18. Respondent office record for Patient E

18A. St. Joseph's Hospital record for Patient E

19. Crouse Hospital record 6/9/04-6/20/04 for Patient E

20. Crouse Hospital record 6/20/04-7/10/04 for Patient E

21. Respondent Office record for Patient F

22. Harrison Surgery Center record for Patient F

23. Crouse Hospital record 7/30/00 – 8/18/00 for Patient F

24. Respondent's letter dated 12/3/03

25. Respondent's letter dated 10/26/03

26. Respondent's letter dated 2/3/07

27. Transcript of Respondent's interview of 12/27/06

28. Transcript of 2005 testimony of Patient F's husband, Patients A, B and C

29. ACOG Bulletin – Operative vaginal delivery

30. N/A

31. Transcript of testimony of David Brittain, M.D.

A. Answer to Statement of Charges

B. 2005 Hearing testimony of James Steven Burkhart, M.D.

C. CV of James Steven Burkhart, M.D.

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

I. N/A

J. Medical examiner summary, 2001

K. DOH Interview of Patient E

This hearing and the cornucopia of charges upon which it is based has its genesis in animus and rumor when Patient "A's" 2001 delivery ended with a still birth.

Despite autopsy findings which revealed that the fetus was virtually without any blood at the time of delivery, due to nuchal cord compression (Exhibit "9"), Dr. Caputo's hospital privileges to perform forceps assisted deliveries were temporarily suspended with no opportunity afforded to him to defend himself on the issue. The basis or reason for the suspension has never been shared with or proven to this Hearing Panel by the State. False rumors circulated that he had caused injury to the skull of the fetus via forceps use and/or killed the fetus due to forceps use. These false rumors even reached other of Dr. Caputo's patients, surprisingly the source being another physician in the community (see testimony of Patient "B" Exhibit "28" at pp. 521-22).

Without notice or warning, persons the State has never disclosed, generated complaints to OPMC as to Patients "B" and "C" when in truth and fact neither deliveries were ever the subject of concern, complaint or peer review within the hospital and OB-GYN Department where Dr. Caputo did and continues to practice and hold privileges. Both deliveries were successful forceps rotation deliveries.

Patients “A”, “B” and “C” continue to see and receive medical care from Dr. Caputo. He is their doctor. They trust him. See Exhibit “28”.

Dr. Caputo has been consistently vigilant in his defense even to the point of appearing intemperate in his writings. It is a matter of understandable frustration. This panel has had the opportunity to see him, to hear him, to size him up. Was he intense? Certainly! Was he respectful? Certainly! Did he over emphasize or repeat himself in his answers to questions posed? Sure. Is that a vice to hold against him when his license to practice his chosen profession of medicine and to provide for his wife and children is at risk? Certainly not! Was his medical school training lacking? No! Did his experience level and training up to and including the year 2000 justify his medical practice to the extent of the types of procedures in issue herein? Absolutely! These preliminary remarks within this paragraph are meant to lead into the next area of true concern – a concern that this panel must voice amongst themselves and likely would do so even in the absence of these written remarks.

Someone who drafted these accusations against Dr. Caputo saw fit to say that he practiced medicine incompetently on more than one occasion and practiced medicine with gross incompetence on a single occasion.

In their own submissions, these accusers have announced that the legal definition which they must prove by the evidence is that “incompetence is a lack of requisite skill or knowledge to practice medicine safely “(Exhibit “1”). Yet a full search of the record which makes up this hearing, fails to identify one speck of evidence on the subject matter of incompetence. Not one question was posed on Dr. Caputo’s skill level or knowledge level in relation to the alleged criticisms connected to these four patients. Not one. No

questions posed ever used the words incompetence, skill or knowledge. In fact the State's only witness, Dr. Tatelbaum made it very clear that these were all standard of care issues rather than competence issues when he stated on cross exam, "I'm not impugning your experience, only your judgment (Record at p 1059).

It is only correct and necessary that the second and fourth specifications alleging incompetence be promptly and expeditiously dismissed for complete and total lack of proof.

There can be very little more unsettling than a circumstance such as this hearing where a medical doctor and the livelihood dependent upon his license to practice medicine rises or falls based upon a hearing panel decision as to which expert they might choose to believe. The burden and obligation on this hearing panel is indeed a substantial one. They should know that any appellate or review authority looking over their decision in the future, cannot substitute their own opinion for that of the hearing panel as to which expert testimony to credit. The law will not allow it.

If this panel feels they are not sufficiently convinced on any given issues by the testimony of Dr. Tatelbaum, then the state has failed in their burden of proof and there is no need nor should the panel go on to consider the testimony of Drs. Burkhart, Stahl or Caputo. To do so would be improperly shift to Dr. Caputo a burden of proof when he has none. This is the law.

If the panel has considered the State's expert proof as well as respondent's expert proof and is not convinced that one is more believable than the other, then this panel has no option other than to find that the State has failed to prove their case against Dr. Caputo. This is the law.

It is only when the hearing panel can say in their hearts and in their minds, based upon the evidence and the law, a certainty of belief in the States expert and a certainty of disbelief as to respondent's expert, that an adverse finding against Dr. Caputo would be legally allowed.

It is respectfully submitted that certain evidentiary comparisons are justified.

AS TO DR. TATELBAUM AND DR. BURKHART

Both practice in Rochester, NY

Both are New York State licensed

Both are OB-GYNs

Both are members of ACOG

Both have been relied upon by the State of New York Dept. of Health to review files and offer opinions and testimony as to medical care provided by other doctors.

Dr. Tatelbaum no longer practices obstetrics nor does he perform major gyn procedures (Records pp. 70)	Dr. Burkhart has been in continuing private practice since 1986 performing obstetrics and also gyn surgery (Exhibit "B" at p. 1125).
He offered no details as to his forceps and/or vacuum training during residency (Record pp. 67-72)	His residency was extensive in the use of forceps and extensive in the use of vacuum (Exhibit "B" at p. 1126).
He offered no information as to the annual average of his operative vaginal deliveries (Record pp. 67-72)	Since 1986 he averages 100-175 yearly deliveries, 10 percent of which are operative vaginal deliveries (Exhibit "B" at p. 1127).
He offered no information as to his average number of forceps deliveries (Record pp. 67-72)	In the past five years he has performed 70-80 forceps deliveries (Exhibit "B" at p. 1128).
He offered no information as to his number, <u>if any</u>, of forceps rotation delivers or mid-level forceps deliveries (Record pp. 67-72).	In the last five years he performed approximately on forceps rotation delivery per year and five mid level forceps deliveries per year (Exhibit "B" at p. 1278).

It is respectfully submitted that this panel would be well within their discretion and authority to keep in mind Dr. Caputo's plea to the DOH voiced back in December of 2003 "**that whoever is selected as a reviewer, that that person have significant experience with complex forceps deliveries in order to do the job [of review] properly (Exhibit "24" at page 16 ¶2).** It certainly seems fair and reasonable to say, and for this hearing panel to conclude, that the proven credentials outlined by Dr. Burkhart, meet that request, in contrast to that of Dr. Tatelbaum. While this is by no means an effort to disrespect or demean Dr. Tatelbaum, it must be said out loud that the contrasts are present, when the stakes for Dr. Caputo are so high.

As the evidence is reviewed, analyzed and discussed one might wonder – one should wonder – how can two Rochester based, ACOG certified, OB-GYNs have such apparent conflicting opinions with regard to these forceps use cases (Patient A, B & C) and this laparoscopy case (Patient F). The answer is most likely found in the language they used. Regularly Dr. Tatelbaum would refer to what "a reasonable and prudent OB-GYN would do". Such an analysis is self-limiting, incomplete and unjustifiably close minded. For example, the fact that a reasonable and prudent OB-GYN would have ordered a bio-physical profile before sending a patient like Patient A in for an elective C-section at 37 2/7 weeks could very well be true, DOES NOT mean it was a deviation on the part of another physician to make the decision based upon placental grading.

Both can be reasonable and prudent exercises of medical judgment. Both would be. Both are. Dr. Tatelbaum leaves no room for such judgment. Dr. Burkhart does and ACOG does (see Exhibit "29"). This is the format of hard thinking and intellectual medical honesty we ask of the panel members.

AS TO PATIENT "A" (9/01) DELIVERY)

Patient "A" was being followed in 2001 by Dr. Caputo for her first pregnancy (see Exhibit "4" generally). She had been in the hospital during gestation on a number of occasions for pre-term labor (See Exhibits "4" and "5" generally and Exhibit "28" at pp. 559-608). In early September 2001 she was diagnosed at office visits as experiencing persistent painful contractions (Exhibit "4" at p. 5).

On 9/12/01, in connection with an office visit, Patient "A" was hospitalized for cellulitis (See Exhibit "5" generally). During this hospitalization, for the first 5 days, and while being treated for the cellulitis, Patient "A" continued to experience painful persistent contractions, was in a lot of pain and was taking medication for the pain (Exhibit "5" at pp. 58-81, Exhibit "28" at pp. 560-61).

By the Saturday of this hospitalization, Patient "A" began to show cervical changes. She was at 37 weeks + 1 day gestation and admission to labor and delivery for rupture of membranes and planned vaginal delivery was recommended (Exhibit "28" at pp. 564-65). She had been writhing in bed in pain and on physical exam showed cervical change to 1-2 centimeters with 50 percent effacement at -3 station (Record pp. 910-911).

Up to this point in time the patient was quite uncomfortable, had not been sleeping and had been experiencing contractions in the hospital for the past 5 days (Exhibit "28" at pp. 564-66, Exhibit "5" at pp. 58-81). While in labor and delivery she continued to experience contractions and attempted to push. She learned that the baby was "facing up". She "pushed with everything I had"; she was "definitely exhausted" and "had given 100% effort" (Exhibit "28" at pp. 567-70).

Forceps rotation and delivery was offered by Dr. Caputo (Caputo at pp. 671-74). Rotation was unsuccessful and was followed by direct forceps delivery from the OP position. It was during these time frames that the fetal monitor revealed a substantial late deceleration and then some difficulty picking up a fetal heart rate.

During delivery it was observed that there was a nuchal cord which was very tight. Dr. Caputo was able to reduce the chord by slipping it over the shoulder when it was unable to come over the head of the fetus. The fetus was stillborn. Kleihaur-Betke testing was negative however, the baby's hematocrit revealed substantial blood loss to the level of 12% (Exhibit "5", pp. 104). Subsequent autopsy confirmed the enormous blood loss to be due to nuchal cord compression (Exhibit "7A").

In connection with this patient the specification of charges allege gross negligence, #1(A.2), A.3) gross incompetence #7 (A.2, A.3); negligence #13 (A.1-A.5); incompetence #14 (A.1-A.5) and inadequate record keeping #15 (A.8).

Nowhere in the testimony of the State's expert, Dr. Tatelbaum, is there any questioning or comment at all regarding the subject matter of incompetence. Incompetency in these proceedings is a legal term of art. It is definable. The elements which make up it's definition must be the subject of evidence produced by the State. Here there was none. As such the Administrative Law Judge should direct and the hearing panel must find that specifications #7 and 14 be dismissed and/or denied.

As to the issue of gross negligence, there was no testimony on that topic unless Dr. Tatelbaum's characterization that the decision to proceed with forceps rotation and delivery was a "significant" deviation (Record p. 129) is deemed sufficient on other patients he chose to use the word "gross". It is submitted that this characterization does

not meet the level of proof required in connection with the definition of gross negligence. Moreover, there was no such characterization at all regarding the claim involving Pitocin management. As such the allegations under specification #1 (A.2, A.3) and #7 (A.2, A.3) must be dismissed and/or denied.

Dr. Tatelbaum criticizes record keeping in relation to this 2001 delivery commenting that there were no medical indications written down to justify rupture of membranes and no documented indications for use of the forceps.

There is no "per se" inviolate directive which indicates what must be contained in a medical chart in order to meet standards of care. The record, to the extent read or reviewed by another OB-GYN should give that health care provider an understanding as to the developing condition(s) of the patient, the care and treatment provided in connection and the patient response to the same and the entirety of the chart can be used for this purpose (Burkhart pp. 1167-68).

ACOG's own practice bulletin on operative vaginal delivery (Exhibit "29") does not direct any specific charting protocol.

A review of the chart for Patient "A" (Exhibits "4" and "5") clearly reveals:

- a patient with persistent painful pre-term contractions,
- a patient hospitalized for pre-term contractions,
- a patient hospitalized for cellulitis on 9/12/01 who while in the hospital continued to experience painful contractions requiring medication.
- a patient in stage two of labor in the early morning hours,
- a patient in stage two of labor with fetus in OP position at +2 station,

- a prolonged deceleration prior to 1:00 AM, down into the 60's and lasting nearly five full minutes,
- fetal heart monitoring strip between 1:45 and 2:15 AM which appeared ominous and consistent with cord compression, showing moderate to severe variable decelerations.

All of these features are fully represented in the patient chart(s) and reveal the condition, the treatment choices and the outcomes. They are perfectly paralleling with an operative vaginal delivery accomplished consistent with the ACOG practice bulletin (Exhibit "29") to the extent it documents "suspicion of . . . potential fetal compromise" and "shortening of the second stage of labor for maternal benefit".

The criticisms by Dr. Tatelbaum as to charting are not only incorrect, they are wholly unexplained. Nowhere in his testimony does he offer any explanation or extrinsic support for his opinions on charting.

It is respectfully submitted that one must also consider the unique circumstances of this catastrophic still birth when analyzing the alleged charting failures. First and foremost, it absolutely must be understood that this delivery note was written two hours after a completely unexpected catastrophic stillbirth that encompassed extreme emotions from the patient, her husband, their entire family and Dr. Caputo himself. This was in no way and must not be considered in any way a normal or even close to normal outcome, even in the unpredictable world of obstetrics. There was no immediate explanation as far as could be ascertained at the time for the stillbirth. To now criticize a delivery note written two plus hours after such an event with these other extraneous factors present is unfair. It should be recognized for what it is, an isolated incident relative to charting.

Here there was an unexplained death of a baby. Here there was a family out of their minds over the event that had just unfolded. Those two hours had focused in the search for an explanation to the family such that when the note was written, it was done so while still in this frame of mind. The reference in the delivery note to "normal heart rate tracing" was specifically in the context that this heart rate tracing was not bad enough to cause the death of this baby in the time frame of this delivery. Aside from the already discussed and described variable decels, this was a normal, healthy heart rate tracing and thus a healthy baby specific to oxygenation and an expected live birth outcome.

The records clearly show all that it needed to determine the state of affairs leading up to the decision to use forceps and get this baby delivered. Just because it is not written down in specific terms is not a deviation from the standard of care. The patient record speaks volumes as to how exhausting her last two weeks of pregnancy truly were. She too testified clearly to these facts (Exhibit "28" at pp. 567-70). And the issues with the heart rate tracing's variable decels and their natural history if left unaddressed are a given.

While it would be nice to have a medical record expressed in a stream of consciousness format, this is unrealistic. Depending on the information being documented, invariably things are left out. The record is supposed to represent the general and specific events of the care rendered to any given patient. (See case law cited herein relative to Patient "C"). Many times in many cases, the record must be thoroughly examined in order to piece together the full story. In other words, it is not always spelled

out in one single location. This is certainly not an excuse for superficial record keeping, but it is the reality of medical documentation.

Furthermore, despite the criticisms of this particular delivery note, it unto itself absolutely diverges from the usual details contained in similar notes for other such deliveries performed by Dr. Caputo (Exhibit "12" at pp. 3, 101; Exhibit "17" at pp. 52-53). While it is maintained that this note is not a deviation, in order for such a claim to be pursued to the level of an OPMC hearing it should have to be a habitual occurrence or problem. In other words, if the norm for a given physician is to document these and other medical events adequately, the one time such information is not specifically laid out but yet available in the chart does not a prosecutorial issue make. No physician could ever be expected to be held to such a standard.

As such the allegations of inadequate record keeping for this 9/01 delivery have not been proven (have been disproven) and to the extent they are referred to in the Fifteenth Specification of Charges, must be dismissed and/or denied.

This leaves the hearing panel with the claims or allegations of negligence. In his testimony Dr. Tatelbaum offers what appears to be a series of criticisms (Rupturing membranes at -3 station; failure to reduce or turn off the Pitocin because it was hyper-stimulating the cervical changes; application of forceps without seeing if the patient could accomplish descent by pushing).

In the reality of labor and delivery these are all only one claim and they should be treated as such.

It is astounding to observe that Dr. Tatelbaum rejects the notion that pushing had not been attempted. He was not there. Dr. Caputo was present and more significantly Patient A was most certainly present. She has informed this panel (Exhibit "28" at pp. 567) that she "pushed and pushed". How Dr. Tatelbaum can cast that aside simply by announcing "so she said", is rather incredulous.

For these issues this hearing panel should start at and regularly return to the following starting point. ACOG (Exhibit "29") makes it very clear that the second stage of labor can be shortened by intervention with forceps assistance when there are fetal indications and maternal exhaustion indications. A physician who complies with those guidelines is always within acceptable standards of care.

Dr. Tatelbaum recognized that proposition but refuses to acknowledge the reality presenting itself with Patient "A". There are cord compression symptoms and this patient is exhausted. It is a recipe for concern yet Dr. Tatelbaum suggests that management requires the Pitocin to be turned off and this exhausted patient to be encouraged to push when she cannot.

At 2:15 AM patient management via observation and encouragement to push is not what standard of care requires. As per the testimony of Dr. Burkhart, while it was an option, it was one that would put this fetus at risk given the fetal heart monitor tracings (Exhibit "B" p. 1151).

Under any view of the evidence, there were sufficient and acceptable medical indications to justify forceps rotation/delivery at 2:15 AM.

- the fetus was in OP position and remote from delivery (Exhibit "B" p.

1149)

- the patient was fully dilated and at or below zero station (Exhibit “B” p. 1149)
- the patient was exhausted (Exhibit “B” p. 1149, Exhibit “28” p. 567-70.
- there was a non-reassuring fetal heart tracing (Exhibit “B” pp. 1140-49) (Exhibit “8” at p. 2) which justified and created in fact, a suspicion of potential fetal compromise.

Emphasis must be made at this time as to Dr. Burkhart’s experience and qualifications.

- He was trained as an OB-GYN resident here in Upstate New York (Burkhart at pp. 1121).
- His training included mid-level forceps rotation/delivery (Exhibit “B” at p. 1127).
- He has practiced in the specialty field of OB-GYN in Upstate New York since 1986 (Exhibit “B” at pp. 1121-23).
- In his 18 years as a practicing OB-GYN in Upstate, New York he continues to employ mid-level forceps rotation/deliveries currently averaging one per year (Exhibit “B” at p. 1278).
- He teaches OB-GYN residents here in Upstate New York (Exhibit “B” at p. 1124).
- He reviews files in consultation from time to time on medical standard of care issues for attorneys in licensing, credentialing and civil litigation settings and also in hospitals settings for quality assurance/peer review

(Exhibit “B” at p. 1129).

- He has been called upon and relied upon by the New York State Department of Health Office of Professional Medical Conduct for file review and hearing testimony (Exhibit “B” at p. 1129).

Consistent with the records, consistent with the literature allowed into evidence and backed by years of knowledge, training and regular, repetitive actual practice in mid-level forceps rotation/deliveries, Dr. Burkhart has shown via both quality and quantity of testimony that Dr. Caputo had more than sufficient medical indications to meet standards of care as it relates to Patient “A” and the choice to proceed with forceps assisted delivery.

As such the allegations of insufficient medical indications for rupture of membranes, Pitocin management and a forceps assisted delivery have not been proven (have been disproven) and to the extent they are referred to in the First and Thirteenth Specification of Charges, they must be dismissed and/or denied.

The last matter of comment and criticism by Dr. Tatelbaum was in relation to the timing of transfer of the baby to the pediatric team. He seems to surround this with comments and interpretations that critical time was allowed to expire given that the cord was not clamped and cut as contrasted with Dr. Caputo’s decision to reduce the nuchal cord by sliding it over the shoulder of the fetus, delivering the fetus and allowing the father to cut the cord, then milking the cord so as to return blood back to the fetus.

Much ado was made about the cause of this fetal demise. Dr. Tatelbaum suggests the blood was subgaleal (between skull and skin around skull). Dr. Caputo indicates the nuchal cord prevented blood flow back to the fetus and it pooled or collected in the

placenta. Dr. Tatelbaum rendered his forensic thoughts on this topic based upon the Autopsy report (Exhibit "7A") but he gave no consideration to the findings the pathologist had communicated to Dr. Caputo (Exhibit "J", that there was no evidence of forceps trauma other than which is typical and expected).

None of these comments were offered to support an alleged deviation relative to cord reduction and while Dr. Tatelbaum is clearly attempting to suggest delay, he indirectly contradicts himself by recognizing the medical judgment and meaningfulness of "milking the umbilical cord" even though he felt that should be performed at a level below the abdomen.

Nowhere did Dr. Tatelbaum recite the necessary events of this special delivery/cord management and how much time it could require. He simply jumps to the speculative, if not incorrect conclusion, that it must have taken extra time to slip the cord over the shoulder/deliver/cut and milk, than it would to clamp and cut/deliver (ignoring that the opportunity to perform the legitimate medical procedure of milking the cord would have been lost).

The testimony of Dr. Burkhart rings in good sense and reason (Exhibit "B" pp. 1157-58), 1191-92). There are numerous ways to accomplish cord reduction. Provided you reduce the cord, it is not a standard of care issue. Dr. Caputo did so.

As such the allegation of improper nuchal cord reduction has not been proven (has been disproven) and to the extent they are referred to in the Thirteenth and Fourteenth Specification of Charges, the must be dismissed.

AS TO PATIENT "A" (12/03) DELIVERY)

The State asked no questions at all relating to the legal standards required for and mandatory elements of proof relative to "incompetence". For that reason the Administrative Law Judge should direct, and the hearing panel must find, that the State has failed to sustain their burden of proof as to specification #14 (A.6 and A.7)

In addition, the State asked no questions at all nor produced any evidence at all with respect to the adequacy of medical records for the 2003 pre-natal care and delivery. For that reason, the Administrative Law Judge should direct, and the hearing panel must find, that the State has failed to sustain their burden of proof as to specification #15 (A.8). There are no specifications alleging gross negligence or gross incompetence in relation to this 2003 delivery nor was there any testimony on these topics.

The only subject matter before this panel is at factual allegations A(6)(7) and the only evidence offered was the testimony of Dr. Tatelbaum who at (Record p 91) opined it to have been a deviation from standards of care to deliver without determining fetal lung capacity via amniocentesis and/or biophysical profile. Therefore A(6)(7) can only be a single claim with a single decision by the panel on specification #13 (A.6 or A.7)

Dr. Tatelbaum rejects the notion that placental grading can be a sufficient screening tool in relation to fetal lung maturity. This testimony should not be credited. In the first instance, his initial comments described three methods to determine fetal lung maturity – collect/analyze amniotic fluid, ultrasound and placenta grading (Record at p.90). That he describes one as the gold standard does not and cannot discount the other two methods. As such there was no deviation from standard of care given that Dr.

Caputo ordered and clinically considered the results of both ultrasound and placental grading.

Dr. Tatelbaum, in his testimony regarding placental grading and the capacity to analyze the same admits that he is not comfortable, nor confident in his own level of knowledge and skill in that area (Record at pp 115-119). This self described lack of credentials requires that his opinion be rejected as it has no foundation or basis.

Both the testimony of Dr. Burkhart (Exhibit at 1207-1231) and Dr. Caputo (Record 1168-1214) explain that the delivery was perfectly acceptable given the mother's past delivery history, the suspicious deceleration observed at the nonstress test of 12/4/03 and gestational age of 37 2/7 weeks.

Consistent with Dr. Tatelbaum's initial testimony, Dr. Caputo ordered an ultrasound given the suspicious nonstress test (Record at pp 1179-80). The sono photos showed adequate fluid (Exhibit "10", Record at p. 1188, Exhibit "B" Burkhart at 1217). Consistent with Dr. Tatelbaum's testimony, placental grading was obtained, observed and clinically correlated by Dr. Caputo (Record at 1184-1214). Moreover, part of his actual residency training – unlike that of Dr. Tatelbaum's – was with regard to the value of being able to predict fetal lung maturity by way of placental grading (Record at 1189). See also (Exhibit "B" Burkhart at 1214).

This hearing and these charges against Dr. Caputo seek to discipline him for malpractice. On this aspect of patient care, while there seems to be opposing expert testimony, due process and fairness requires the panel to ask how could there be such an apparent diversion in opinion. The answer lies in the fact that Dr. Tatelbaum's initial training and experience is from a slightly different time and admittedly did not include

education that emphasized the relationship between fatal lung maturity and a grade three placenta. In reality Dr. Tatelbaum's testimony does not show proof of a deviation. It is simply his observation that he would have tested differently.

Specifications #13 (A.6) and (A.7) must be denied.

AS TO PATIENT "B" (9/03 DELIVERY)

At the outset, the hearing panel is reminded that as to Patient "B" the state has included charges and specifications alleging gross negligence, gross incompetence and incompetence. They are at Specifications #2 (B.2)(B.3), #8 (B.2)(B.3) and #14 (B.2)(B.3).

The state asked no questions at all relating to the standards required for and mandatory elements of proof relative to "incompetence". For that reason the Administrative Law Judge should direct, and the hearing panel must find, that the State has failed to sustain their burden of proof as to #8 (B.2)(B.3) and #14 (B.2)(B.3).

While there were times when Dr. Tatelbaum was asked to characterize the level of the deviation he was offering his opinion on, none of those questions were posed to him in regard to Patient "B" (Record at 473-551).

This represents a complete failure in proof both as a matter of law and of a matter of fact on the topics of gross negligence and gross incompetence. For the hearing panel to attempt consideration of these specifications on the merits, they would only be able to do so via surmise and speculation, which is prohibited.

The Administrative Law Judge should direct, and this hearing panel must find, that the State has failed to sustain their burden of proof as to Specifications #2 (B.2)(B.3),

#8 (B.2) (B.3) and #14 (B.2)(B.3). What this leaves for panel consideration are claims of negligence and inadequate record keeping at #13 (B.2)(B.3) and #15 (B.4)

Patient "B" was 33 years old. This was her first pregnancy. Her estimated date of confinement was 9/9/03. On 9/10/03 she was seen in the office and examination revealed that she was 40 plus weeks, 3 cm dilated, 80 percent effacement at -1 station. Dr. Caputo admitted her to the hospital for early labor (Exhibit "11" at pp. 9-10).

Once the patient reached second stage she pushed for three hours. The fetus was in occiput transverse position. The patient was offered and agreed to an attempt at mid-forceps rotation/delivery Exhibit "12"; "28").

A vacuum extractor was used to bring the fetal vertex down a millimeter or two after which time the Keilland forceps were placed and rotation was accomplished. The Keillands were replaced with Leukart-Simpson forceps and delivery was accomplished (Exhibit "12").

It appears that the State might be claiming that it was a deviation from standards of care on the part of Dr. Caputo in that he did not perform patient vaginal exams every hour when she was pushing from 3:34 a.m. to 7:00 a.m. The issue is very unclear given the questions posed to and the style of answers provided by Dr. Tatelbaum.

He does not say there was a deviation from a standard of care. He does say that it "would probably vary among practitioners (Record p. 477) and while he does comment that a doctor "probably would want to check at least every hour" (Record p. 477) it is ultimately characterized in conclusion – not with language that it was a deviation – but rather by remarking "I would think" (Record p. 477). The analysis seems to ignore the very realities of this medical record.

The chart (Exhibit "12") documents on pages 80, 104: a vaginal exam at 2:45 AM "with Dr. Caputo aware"; on page 81 that "the baby's head is more in place" at 3:34 AM with "Dr. Caputo notified"; on page 82 that "the patient is pushing" at 4:29 AM; on page 83 that the "head making a little more progress" at 6:48 AM; on page 104 a vaginal exam at 7:00 AM with "Dr. Caputo aware"; on page 83 that "Dr. Caputo is in to do forceps attempt".

As explained in the testimony of Dr. Burkhart "the record has to be taken in its entire context. There are other people generating records here. We are also taught in obstetrics and gynecology to refrain from doing examinations when they are unnecessary so as not to increase the chance for infection (Exhibit "B", Burkhart at pp. 1239); "it would be physician's choice based upon a clinical presentation, based upon movement of the baby's head, based on frequency of the exams, . . . based on wanting to make sure that you're not going to cause infection, based on how long you wanted to wait to diagnose your transverse arrest, based on how long you want to wait before you decide you're going to do something about it" (Exhibit "B" at p. 1245). There was no charting deviation on Dr. Caputo's part.

Noteworthy is the actual working knowledge on the part of Dr. Caputo as to how and what the nurses do in labor and delivery during second stage, often in the absence of the doctor. They perform vaginal exams, they regularly re-position the patient and he is confident they did so for this patient (Record pp. 1220-1302).

Dr. Tatelbaum seems to criticize the use of the vacuum and the forceps (Record at 486-488) and criticize the fact that they were utilized to deliver this baby rather than just

proceed with a cesarian section (Record at 490, 494). The opinions are one and the same in addressing a single issue.

Dr. Tatelbaum takes the position that one cannot and must not place a vacuum extractor or forceps without having been able to ascertain the posterior fontanelle, the anterior fontanelle and the sagittal suture line (Record pp. 486-488). He does not describe his experience level with vacuum placement. He does not identify or describe the basis for his opinion – training, education, medical literature – other than to say that "the rules of the game with vacuum are very specific . . . ." (Record pp. 486-487) and that placement must be "2 centimeters in front of the posterior Fontanelle" (Record p. 487).

A review of the pertinent medical records and testimony do not indicate that this placement could not be or was not accomplished. When asked on cross exam "wasn't one of the driving forces behind the development of vacuum such that it did not require an absolute determination of the fetal head position in order to utilize it?" (Record p. 528), his reply was not a definitive "No". It was simply that it is "not his understanding of how the vacuum is currently used" (Record p. 528).

In contrast Dr. Caputo explained at length the differences between vacuum and forceps in relation to placement determinations (Record pp. 1220-1303) and Dr. Burkhart has made it perfectly clear that utilization of the vacuum to move the fetal head slightly so that forceps can be properly and safely placed is acceptable and within standards of care (Exhibit "B" at pp. 1240-1248). In fact he had used vacuum in this very same way "a couple of times in the past five years" (Exhibit "B" at 1278-79).

While this might not be the way Dr. Tatelbaum makes determinations regarding vacuum placement or forceps placement, it just does not reach the level of evidentiary reliability to say that these approaches constitute to deviation from standards of care.

Specifications #13 (B.2)(B.3) and #15 (B.4) must be denied.

AS TO PATIENT "C" (8/03 DELIVERY)

At the outset, the hearing panel is reminded that as to Patient "C" the state has included charges and specifications alleging gross negligence, gross incompetence and incompetence. They are at Specification #3 (C.1)(C.2), #9 (C.1)(C.2) and #14 (C.1)(C.2).

The State asked no questions at all of their witnesses relating to the standards required for and mandatory elements of proof relative to incompetence. For that reason the Administrative Law Judge should direct, and the hearing panel must find, that the State has failed to sustain their burden of proof as to #9 (C.1)(C.2) and #14 (C.1)(C.2).

As it relates to this specific patient and the deviations opined to by Dr. Tatelbaum, he was given the opportunity to characterize the level of the deviation. This question as to Patient "C" was focused only on Dr. Tatelbaum's opinion as to Respondent's decision to rupture membranes. Unlike other patient cases where he pronounced the level of negligence to have been "gross", for Patient "C" and this singular issue he declined to do so stating "I think I'd rather just leave it - - it wouldn't be prudent for a reasonable physician to do that" (Record at P. 558).

This represents not just a complete failure in proof on the allegations of gross negligence, it is definitive proof by the state that it was not gross negligence. For these reasons the Administrative Law Judge should direct, and the hearing panel must find, that the state has failed to sustain their burden as to #3 (C.1)(C.2).

What this leaves for the hearing panel are claims of negligence and inadequate record keeping at #13 (C.1)(C.2) and #17 (C.3).

This patient was 33 years old. She had a previous first pregnancy in 2000 involving delivery by low transverse cesarean section of a nine pound six ounce child from breach presentation (Exhibit "13" at pp. 6-7).

In 2003 she came under Dr. Caputo's care at approximately 15 weeks into her second pregnancy. Vaginal birth after cesarean (VBAC) was planned (Exhibit "13" at pp. 7).

The patient was seen in the office on 8/20/03. She was a 39 weeks + 3 days, four day short of her EDC. Vaginal exam revealed that she was 2-3 centimeters dilated with 90% effacement at -2 station (Exhibit "13" at pp. 7).

She was scheduled for induction the next day at Crouse Irving Memorial Hospital. During the course of her labor, fetal presentation was noted to be OP. A mid-level forceps rotation/delivery was accomplished successfully at 4:37 PM Exhibit "14" at pp. 52, 53, 56).

The positions offered by the experts seem diametrically opposed. Dr. Tatelbaum states that inducing labor three days before EDC is unjustified as it is without medical justification. An explanation is not really offered except to say that induction carries with it complication risks. Otherwise he says that fetal or maternal medical issues are lacking, therefore "standard management for that patient" is observation.

Dr. Tatelbaum refused to recognize the prior delivery of a 9 pound 7 ounce child as having any role or relationship in the current delivery planning for a VBAC.

Dr. Tatelbaum seems to ignore the fact that the patient had been very uncomfortable, had specifically indicated to Dr. Caputo a desire "to get the ball rolling" and that the option to induce the next day was offered, explained and was left totally up to the patient (Exhibit "28" at pp. 537-538). The evidence shows that after thirty minutes of pushing an OP positioned fetus the patient was in agony and begging for relief (Exhibit "14" at pp. 52, 53). Dr. Tatelbaum wholly contradicts his own opinion he acknowledges as being "correct" that alleviating her pain by delivering her baby is an option (Record at p. 605).

The testimony of both Dr. Caputo (Caputo at pp. 927-1016) and Dr. Burkhart (Exhibit "B" Burkhart at pp. 1255-1281) takes the position that induction at this time for a VBAC desirous patient who was at term, showing cervical change, substantial cervical effacement and whose prior child was a good sized baby, was one of a number of acceptable delivery management options. In fact, this delivery by its very timing, **minimized** both maternal and fetal risk.

No literature, ACOG materials, or authoritative sources were produced to explain how the delivery approach was a departure from standards of care. It seems, sounds and reads as if this is another review format by the State expert which is being guided, not by what Upstate New York standards of care are or might be, but rather is simply his own version of what he would have done under similar circumstances.

It is submitted that the deviation alleged has not been proved and to the extent it is referred to in the Thirteenth Specification of Charges, must be dismissed and denied.

Dr. Tatelbaum also offered the opinion that there were no fetal or maternal indications to utilize forceps in the delivery. However the position by Dr. Tatelbaum is

anything but definitive and seems to more properly fall into that category of what he himself would have done or recommended. Nowhere does Dr. Tatelbaum state that it was a deviation to proceed with forceps. He just emphasizes the option of pushing with additional analgesics. As can be seen in the record at p. 563 Dr. Tatelbaum – on direct exam – states that the management options available to a reasonably prudent obstetrician were "continue pushing, repeat caesarean section, or in this case the discussion was forceps. You could, I suppose, use a vacuum to move towards delivery at that point . . ."

Dr. Caputo proceeded with one of those acceptable options - forceps. He cannot be accused of negligence based upon this testimony. ACOG guidelines (Exhibit "29") allow him to shorten the second stage and deliver via forceps for maternal benefit. This patient was in agony with a fetus in OP position (Exhibit "14" at pp. 52-53) and could not push any longer. This was a reasonable and prudent exercise of medical judgment (Exhibit "B", Burkhart at pp. 1262-1265).

It is submitted that the deviation has not been proven and to the extent it is referred to in the Thirteenth Specification of Charges, must be dismissed and denied.

The remaining claims raised as to Patient "C" relate to record keeping. Dr. Tatelbaum seems to criticize the documentation/record keeping as it relates to noting the risks and benefits involving a decision to proceed as a VBAC (Record at pp. 553-554); and the identification of the station of the fetal vertex in the forceps delivery note (Record at pp. 571-572).

This is an appropriate time for the hearing panel to know the legal analysis as to the charges being leveled relative to all the record keeping issues. Dr. Caputo **IS NOT** being accused of negligence or incompetence on the topic of documentation (See Exhibit

"1" at p. 8). Dr. Caputo **IS ONLY** being charged in the Fifteenth through Twentieth Specifications of violating Education Law §6530(32). That statutory provision does not contain a directive that discussion of risks and benefits for VBAC management be written down or actual station for a mid-forceps delivery must be placed in the hospital chart. Nor does it direct that patient exhaustion be written in the chart or amniotic fluid level seen on a sonogram be written in the chart, or a specific number of vaginal exams over a three hour time frame of labor be charted The pertinent language of the Statute reads that a physician shall be subject to discipline for "failing to maintain a record of each patient which accurately reflects the evaluation and treatment of the patient . . . ." (Education Law §6530(32)).

Dr. Tatelbaum's testimony does not address these statutory criteria. His concerns are not over a failure from the records such that a reviewer would not be able to understand the evaluation and the treatment. Actually all reviewers seem to have had no difficulty at all knowing and understanding all that Dr. Caputo considered and then did for this, and all other patients. Dr. Tatelbaum's language sounds more in the nature of negligence . . . a claim not leveled against Dr. Caputo with respect to record keeping. Case law interpreting the meaning of this statute indicates that it is only when a medical record fails to convey "objectively meaningful medical information concerning the patient treated, to other physicians" that it can be considered inadequate (See Matter of Miccido, 195 AD2d 623, lv. denied 82 NY2d 661 [1991]; Matter of Gonzales, 232 AD2d 886 [1996]; Matter of Maglione, __ AD3rd _, 779 NYS2d 319).

Dr. Caputo's charting, along with the entries by the team in each hospital setting certainly meets these standards. While it might be said in limited circumstances that the

charting was not perfect or could have been better, a point readily acknowledged by Dr. Caputo, this does not translate into a violation of the Education Law Provision alleged.

The criticisms relative to charting certainly appear minor at best. They certainly do not appear to be habitual, or repeating and they did not render reviewers Dr. Tatelbaum, Dr. Burkhart or Dr. Stahl unable to understand the evaluation of and treatment provided to these patients.

As such the record keeping deviations have not been proved to rise to the level of violating Education Law §6530(32) and to the extent they are referred to in the Fifteenth through Twentieth Specifications, they must be dismissed.

1) **AS TO PATIENT "D" (METHOTREXATE, D&C)**

This patient came over to Dr. Caputo's office for pre-natal care, having had a recent positive pregnancy test (Exhibit 15 p. 33). This patient was documented as being 350-360 lbs. It appears this was her own estimate given that the office scale would not go past 350 lbs. Based upon her identification of her last menstrual period, which the patient said was regular periods until August, she was projected to be 8-9 weeks pregnant (Exhibit 15 p.33: Record pp. 1699-1700).

The standard protocol in Dr. Caputo's office was to secure beta hcg levels and serum progesterone. These were standing orders (Record pp. 162). According to Nurse Practitioner Monnet, the progesterone was wanted only to see if it was less than 20 (Record pp. 1684-1685). The hcg was watched in the first trimester as it was expected it should double (Record pp. 1683).

When the hcg levels dropped, rather than doubled, Nurse Practitioner Monnet called Dr. Caputo who was over in the hospital and informed him of the same. She made

no mention of the progesterone levels, which were high (Record at pp. 1691-1694). This led to an order for and the accomplishment of a sonogram at the office on 11/7/05 (Record p. 1694). A transvaginal sonogram on this morbidly obese patient was accomplished on 11/7/05 (Exhibit "15" a p. 43). There was no evidence of a pregnancy found anywhere in this ultrasound study.

Based upon this data, Dr. Caputo diagnosed a non viable pregnancy. He initially recommended the use of Methotrexate to destroy the pregnancy tissue. It was administered in the office on 11/8/05 (Exhibit "15" at p.34). When this treatment did not appear to be successful he performed a D&C at Crouse Hospital on 11/23/05 (Exhibit "16". When the pathology from the D&C did not reveal any chorionic villi (Exhibit 15 p. 57), the patient was thereafter found at an emergency room visit on 12/7/05 to actually be at 38 weeks of gestation (Exhibit "17").

The allegations regarding Patient "D" refer to gross incompetence and incompetence (Specifications #10 and 14). There were no competency questions asked of the State expert nor were any topics on those legal standards ever developed. In addition while the allegations allege a record keeping deviation (Specification #18), again, nothing was developed on the topic of record keeping as to Patient "D".

The Administrative Law Judge should direct, and the hearing panel must find, that the State has failed to sustain their burden of proof as to Specifications #10, 14 and 18.

What remains is an effort to turn a single diagnosis decision on the part of Dr. Caputo into four separate deviations. Much like the excessive or over-indictments too often used by prosecutors in criminal cases, this is improper and unfair.

The State's expert agrees that Methotrexate is acceptable in order to terminate a non-viable first semester pregnancy. He also agrees that a D&C to terminate a non-viable first semester pregnancy or to address the condition when Methotrexate therapy has failed, is appropriate. Therefore, it is quite incorrect to accuse Dr. Caputo of having violated standards of care in ordering and/or performing these treatments/procedures. His diagnosis supported those decisions. It is that underlying diagnosis which is the only true criticism being offered by Dr. Tatelbaum and this is clearly represented by the words he chose to use when articulating his opinion – "because a reasonable physician . . . wouldn't entertain a treatment without attempting to get more information" (Record at p. 639), "Dr. Caputo did not have a diagnosis. So therefore he should not have entertained any medical intervention without trying to get one. So there was no indication to do the Methotrexate and there was no indication to do the suction curettage" (Record pp. 653-654).

One would think and actually expect that both the State's attorney and the Administrative Law Judge should or would recognize this legal reality, withdrawing and/or directing that Specifications #5 (D.5), 10 (D.5), 13 (D.5) and 14 (D.5) be dismissed. It is the underlying diagnosis which is at issue, not the treatment flowing therefrom.

From this, the hearing panel need only, and must address the negligence/gross negligence claims under "D.1, D.2 and D.3". Once again, these three allegations are improperly and unfairly divided into single standard of care issues. There should be only one.

Not unlike any other patient who is being set-up and organized for pre-natal care, beta hcg is ordered and repeated. Sonogram is ordered. They are not considered separately but rather are intended to be – and were - clinically correlated. This is done for multiple reasons one of which is to establish dates. Therefore, there can only be a singular standard of care issue involving the determination as to where this patient was in terms of gestation. This means D.1, D.2 and D.3 can only be a single allegation for panel. The State Attorney should acknowledge this and the Administrative Law Judge should so direct the panel.

It is indeed enlightening to observe that neither Dr. Tatelbaum nor Dr. Stahl in their private practice experience(s) secure progesterone levels along with beta hcg testing (Record pp. 627, 659-661); Record pp. 1750). Dr. Tatelbaum appears not to have known and therefore he never considered the fact that this was simply a standing order out of Dr. Caputo's office to be brought to his attention if the progesterone level was at or under 20. This might then explain why the State Attorney then attempted to suggest that Dr. Caputo was "making it all up" (See summation, Record pp. 1856-1857). What the State Attorney chose to ignore was the letter Dr. Caputo sent to the DOH (Exhibit "26") wherein it is perfectly clear and perfectly consistent that Dr. Caputo did not know of the actual progesterone values until after the patient had been diagnosed at 38 weeks gestation.

The credible testimony on this remarkable fact pattern came from Dr. Ronald Stahl. The patient description of the last menstrual period is reliable and is relied upon in actual practice. The information available, dropping hcg levels, and the absence of evidence of a pregnancy on transvaginal sonogram, strongly showed a non-viable first trimester pregnancy thus justifying the termination efforts via methotrexate and later

suction curettage (Record pp. 1731-36, 1742). Liver function studies in advance of administering Methotrexate are not mandatory in connection with standards of care (Record pp. 1736-1739) and a transvaginal sonogram is the best ultrasound method of choice for a morbidly obese patient thought to be in first trimester (Record p. 1752).

For these reasons Specifications #4, 10, 13 (D.1-D.5), 14 (D.1-D.5) and 18 must be dismissed and/or denied (or alternatively the only incident which can be legally addressed is that one identified as D.1, and it should be dismissed and/or denied).

AS TO PATIENT "E" (TOCOLYTICS/CERCLAGE)

This patient was seventeen plus weeks pregnant as of June 2004. She had been diagnosed by care providers at St. Joseph's Hospital in Syracuse that she had a subchorionic bleed with contractions (Exhibit "18A") and that she should simply go home to bedrest as she was going to lose the baby (Exhibit "K").

In this context she sought out Dr. Caputo. He accepted her into his service. After advising her of the very remote chances of success, and only with her consent (Exhibit "F"), Dr. Caputo admitted her to Crouse Hospital 6/9/04-7/10/04 (Exhibits "19", "20"). Various Tocolytic agents were administered, monitored and managed in an effort to control the bleeding and contractions. When she started to show cervical change, a cerclage was placed on 6/16/04. It was removed on 7/9/04. Thereafter the pregnancy failed.

For reasons previously stated and repeated, since there were no questions posed to the state expert on the topic of "incompetence" Specifications #11 and 14 must be dismissed and/or denied. Since there was no testimony or evidence offered as to

maintaining adequate medical records, Specification #20 must be dismissed and/or denied.

This instance of patient care is another example of overzealous prosecution "Over Indicting" via their factual allegations and specification of charges. Factual allegations F(1) - (5)cannot by law or fact be segregated in five distinct areas. They are only a single event described at F(1). By his own testimony, Dr. Tatelbaum makes it clear that this matter involves improper management of the patient's threatened second trimester abortion. He does not believe under any circumstance that this patent should have been admitted to the hospital for Tocolytics or cerclage, to the extent he testified that there is "no data to support aggressive management" (Record p. 761); "this doctor seems to think that medical treatment . . . would be possible in someway to effect improvement . . ." (Record at p. 765); "there are no indications for using mag sulfate to treat uterine contractions due to subchronic hemorrhage in the second trimester" (Record p. 770); it's a condition where physicians as human beings don't have the armamentarium to treat . . ." (Record pp. 771); ". . . . Doctors cannot treat this situation . . . ." (record pp. 789); " . . . The outcome is beyond his care" (Record p. 790).

To this end the evidence before the panel seems diametrically opposed. Dr. Tatelbaum seems almost aghast at the medical efforts attempted by Dr. Caputo but the only actual basis for his claim is the limited likelihood of success. Dr. Stahl finds this effort to address the "vicious cycle" of bleeding/contractions" in the second trimester, not only within accepted standards of care but a practice employed by others at Crouse Hospital (Record pp. 1756-1758). Tocolytics are properly used. Cerclage becomes a consideration when cervical changes develop. A Shirodkar style cerclage is used given

that it will involve less manipulation of the cervix. Removal of the cerclage can await observation to see if amniotic fluid levels will return and was timely removed when there was no change (Record pp. 1753-1788).

It seems difficult to believe that ACOG certified physicians could differ so dramatically on this matter of patient care. The explanation is in the language. Dr. Tatelbaum characterized the care as "aggressive management". This is true and obviously he is not willing to make such an effort. Dr. Caputo should not be disciplined merely because he embarked upon an aggressive management plan for a patient who sought it out and agreed to proceed knowing full well that the chances of success were limited (Exhibit "K").

AS TO PATIENT "F"[4] (7/00 LAPAROSCOPIC ADHESION TAKE-DOWN)

This patient was a 53 year old female diagnosed with chronic right lower quadrant pelvic pain likely due to adhesions. She was scheduled for open laparoscopy and lysis of adhesions at an outpatient surgical center on 7/28/00 (Exhibit "21").

The patients past medical and surgical history included hypercholesterolemia, degenerative joint disease, GERD, open cholecystectomy, gastric stapling, appendectomy, right oophorectomy (Exhibit "21").

At the start of the procedure upon entering the peritoneum a small rent in the serosa of a loop of small bowel adherent to the peritoneum was observed. Dr. Caputo extended the incision and repaired the serosal effect.

[4] She would be referred to in the 2005 testimony of Dr. Burkhart, Dr. Brittan and her husband, as Patient "D".

During the procedure the uterus was sounded to eight centimeters and a Kroner set for seven centimeters was placed into the cervical canal and was secured using water in the balloon.

During the procedure, Dr. Caputo observed a small central defect in the uterine fundus which he assumed was caused by placement of or manipulation of the Kroner. There was no bleeding from this defect site.

Otherwise the procedure went without incident. Adhesions were taken down as deemed necessary. Minimal bleeding was incurred during the procedure. The pelvis was copiously irrigated with no evidence of active bleeding. The right and left sided trocars which were placed under direct visualization were removed under direct visualization without any abnormalities visible or suggested. The sutures placed in the serosa at the start of the procedure were examined prior to closure and were intact. Those sutures were still intact when the abdomen was subsequently explored on re-admission. The patient was discharged home with post-op instructions and for a one week follow-up visit at the office (See Exhibit "22" at pp. 2-8). Patient "F" was never called to testify. Through her husband she reports calling Dr. Caputo's office with complaints of fever and pain and having been told to take Milk of Magnesia. There are no such calls documented in Dr. Caputo's office chart (Exhibit "21"). On 7/30 the patient was admitted to Crouse Irving Memorial Hospital through the ER for shortness of breath, RUQ pain and right shoulder pain (Exhibit "23" at pp. 153). She did not have a fever. Two days into the hospitalization concern developed that there might be a small bowel perforation. Via exploratory surgery on 8/2/00 a perforation to the small bowel in the terminal ileum area

approximately a foot from the cecum was identified and repaired (Exhibit “23” at p. 326). The patient was discharged on 8/18/00.

Once again there are charges at Specifications #12 (F1-F5) and 14 (F1-F5) which claim incompetence. No evidence was produced on the subject matter. None of the legal elements of proof constituting “incompetence” were addressed in the State’s case and on cross exam Dr. Tatelbaum made it clear that he was questioning, not competence, but Dr. Caputo’s judgment regarding this patient (Record p. 1059). These specifications must be dismissed and/or denied.

Once again there are charges at Specifications #6 (F1-F5) and 12 (F1-F5) which allege the violation rose to the level of being “gross”. This is a legal term of art. The state must prove this level or degree of violation. It cannot be supplied by guessing or speculation nor may a panel member attempt to employ whatever their own professional experience might suggest on the topic. Unlike other pending patient cases where he was asked to and offered his characterization as to the alleged violations, he offered none as to Patient “F”. For this reason, these specifications must be dismissed and/or denied.

Once again there is a charge at Specification #20 (F.6) claiming inadequate or inaccurate records. A review of Dr. Tatelbaum’s testimony shows that no opinions were offered, directly or indirectly, on that subject matter. As such this specification must be dismissed and/or denied.

Again this hearing panel is confronted with divergent testimony on the issues raised – preoperative consult with a general surgeon; preoperative bowel preparation; predischarge consult with a general surgeon; an earlier re-admit; earlier general surgical consult upon readmission.

It is respectfully suggested and urged that this hearing panel give a very hard look to these issues and ask whether these criticisms by Dr. Tatelbaum are true opinions based upon a reasonable degree of medical certainty or if they are more likely observations touched by the temptation of hindsight. We urge that Dr. Tatelbaum's choice of words be examined with care. On all of these issues, the affirmative answer to the deviation question was nothing more than saying "yes" to a leading question. When his actual rationale was verbalized, it became clear that the analysis falls into that category of "I would have done this differently". As to preoperative surgical consult Dr. Tatelbaum stated "a prudent physician, it would seem, would find it useful to consult . . . "(Record pp. 853-855). As to pre-discharge surgical consult Dr. Tatelbaum stated "I think it would have been helpful . . . ; it is difficult for me to answer that question . . ." (Record pp. 863-864). With regard to directing the patient earlier back to the ER, Dr. Tatelbaum stated "I think probably you would advise the patient to go back to the emergency department . . ." (Record pp. 867-868).

Certainly these comments and characterizations, these words used by Dr. Tatelbaum once he was no longer constrained by leading questions, makes it very clear that they are insufficient to support to a reasonable degree of medical certainty the proposition that Dr. Caputo deviated from acceptable standards of care in the medical judgments that he made for this patient.

Dr. Caputo and other gynecological surgeons have as much experience if not more, than general surgeons in relation to laparoscopic adhesion take down (Record p. 1792). Bowel preparation while an option, is a matter of medical judgment rather than a matter of strict necessity (Record p. 1793-1794). This patient was back into the hospital

two days post-op. While there she received work up through internal medicine and general surgery. Even the general surgical consult, initially, did not see this a case with signs or symptoms requiring immediate surgical exploration (Exhibit "23").

It is submitted that the more reasoned and more reasonable analysis on this patient has been provided by Dr. Burkhart (Exhibit "B") and Dr. Stahl (Record at pp. 1788-1801). That reasoning fully justifies the decision making that must be left to the treating gynecologist and fully justifies a denial as to all the claims making up Specifications #6, 12, 13, 14 and 20.

DISMISSAL IN THE INTERESTS OF JUSTICE

Education Law §6530 allows for this panel to resolve all or any part of these charges by dismissing them in the interest of justice.

Under no circumstance does Dr. Caputo urge such a resolution merely to make things easier for him. The matter does deserve your consideration and attention depending in part on certain of your findings and depending upon the context of that which remains. In Dr. Caputo's behalf I ask the panel to consider the following.

Clearly the issues and elements of proof as to incompetency and gross incompetency have not been addressed by any evidence whatsoever. What remains are allegations of negligence, allegations of gross negligence and allegations of record keeping/charting insufficiencies.

Within those three arenas it seems very clear that numerous of the negligence claims are in reality just a single predicate claim (Patients "D" and "E") and in only a select few areas did the state's expert utter the word "gross" (never with substantive explanation).

It should not go unnoticed that to be positioned to request that discipline be imposed upon a physician, the State must prove more than a single act of negligence or a single act of gross negligence. The effort to do so and the over reaching nature of that effort can well be observed in the case before this panel. Theories and claims have changed randomly from 2005 to 2007. Multiple acts of negligence are written up when there is really only a single issue of medical judgment involved; gross negligence charges are drawn up almost on every topic; is testified as to only a few topics; and is never substantively explained. When the State is not addressing the issues fairly, a circumstance littered throughout this record, it can and should be reflected by how this hearing panel responds to the issues. Does anyone believe there would have been any charges leveled if the only issues were the record deficiencies alleged?

From this context, it would be well within the discretion of this hearing panel to recall and consider the time in practice by Dr. Caputo, his excellent record in relation to patient complication rates at the hospital, the positive belief in Dr. Caputo by his patients (A, B, C, E), and the rather moving testimony of the one witness untouched by "consultation retainers" and probably in the best of positions to tell us all what we need to know about Dr. Caputo – Frances Campbell RN. She, who has been regularly and consistently exposed to Dr. Caputo for <u>all</u> his time in practice in Syracuse, NY stated under oath:

> **"I think he's a very caring physician. He has a good relationship with his patients. They seem to like him. He does a beautiful vaginal delivery. He does a beautiful forceps delivery and he's very meticulous with his C-sections" (Record at p. 1662)."**

Dr. Caputo has been diligently dealing with, addressing openly and confronting these allegations for many, many years. Other doctors (Burkhart and Stahl) have told him he has committed no malpractice. He has never denied that he is the person who made the decisions for and gave these recommendations to his patients. He has not failed in any learning from these patient cases.

It is the 2001 outcome for Patient "A" which guided and assisted in the delivery timing decision for that same patient three years later. It is the sonogram limitations learned by subsequent root cause analysis which led to an office practice protocol by which obese patients are now sent to outside radiology. He has readily acknowledged that some procedure notes and chart entries could have been clearer or more substantial.

The point being suggested is just this. Dr. Caputo has not gone unpunished and he has not failed in having learned from these rather unique medical circumstances. It is from within this context that the hearing panel has every authority, should they choose to do so, to dismiss the charges in the interest of justice.

PENALTY/DISCIPLINE

Certainly this panel is aware that Dr. Caputo's defense to these charges is to address them substantively rather than in mitigation. As his legal counsel and out of full respect to this panel, I must go beyond the substantive defense. I do so recognizing the unnerving reality that this panel has the authority to say, in words or substance, "we choose to believe some or all of the opinions uttered by Dr. Tatelbaum". To that extent I remind this panel, in that event, they are fully authorized to impose no penalty should they see fit. The reasoning and rationale offered on the dismissal in the interest of justice

section applies equally herein. Considering the larger picture, license revocation or suspension or limitation would seem to be clearly excessive.

Dated: September 25, 2007 SMITH, SOVIK, KENDRICK & SUGNET, P.C.

BY:_____

Michael Paul Ringwood, Esq.
Attorneys for Respondent
Office & P.O. Address
250 South Clinton Street
Syracuse, New York 13202
Telephone No.: (315) 474-2911

TO: NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Professional Medical Conduct
Room 2512, Corning Tower
Albany, NY 12237
Attn.: Timothy J. Mahar, Associate Counsel

Hon. William J. Lynch
Administrative Law Judge
New York State Dept. of Health
Bureau of Adjudication
Hedley Building
433 River Street
Troy NY 1218