IN THE MATTER OF	*	BEFORE THE BOARD
SHEO P. SHARMA, M.D.	*	OF PHYSICIAN
Respondent	*	QUALITY ASSURANCE
License Number: D22638	*	Case Number: 94-0702
	*	OAH #96-DHMH-BPQA-71-237

* *

FINAL ORDER AND OPINION

PROCEDURAL BACKGROUND

On May 7, 1996, the Board of Physician Quality Assurance (the "Board") issued charges against Sheo P. Sharma, M.D. (the "Respondent") for failing to meet appropriate standards of care in his medical practice in violation of the Medical Practice Act, Md. Code Ann., Health Occ. §14-404(a)(22) (1994 Repl. Vol. and 1996 Supp.). A Case Resolution Conference was scheduled on August 21, 1996 for possible settlement of the case. Because the parties could not agree to a settlement, the case proceeded to a hearing.

The parties attended a prehearing conference on September 18, 1996. A hearing on the merits of the case was held on March 19 and March 20, 1997. Lindsay S. Waite, Administrative Law Judge, ("ALJ"), presided over the hearing. In a Recommended Decision dated June 18, 1997, the ALJ concluded that the Administrative Prosecutor did not prove by clear and convincing evidence that Dr. Sharma failed to meet standards of care required by HO §14-404(a)(22), and that the charges against Dr. Sharma should be dismissed.

On July 7, 1997, the Administrative Prosecutor filed exceptions to the Proposed

Decision of the ALJ. On July 24, 1997, the Respondent filed a response to the Administrative Prosecutor's exceptions.

FINDINGS OF FACT

After consideration of the record, the Administrative Prosecutor's exceptions, and the Respondent's response to the exceptions, the Board adopts the Findings of Fact as set out in the Proposed Decision issued on June 18, 1997 with the following modifications. These modifications are based on the Board's evaluation of the evidence in the record, using the Board's own medical expertise. The Board had no difficulty in finding that some of the Administrative Law Judge's Proposed Findings of Fact, though based on some evidence in the record, are so contrary to common medical knowledge that the Board felt compelled to find facts to the contrary, based upon the evidence to the contrary which is also in the record.

5. Fetal monitoring strips are not difficult to interpret where the fetus is not functioning normally. The purpose of a fetal monitoring strip is to determine what a baby is doing and whether the baby is functioning normally. The Administrative Prosecutor's expert testified that the interpretation of variable decelerations with late components is "very obvious." The Board agrees completely with this comment.

10. The standard of care when patients are beyond their due date is to perform antepartum surveillance tests (non stress test) after the 40th week and every three days thereafter. A nonnstress test is one in which the obstetrician places the patient on a fetal monitor with an external probe attached to the abdomen. The probe records the baby's heart rate. The obstetrician is looking for movement by the baby. A reactive

nonstress test is a reassuring result. A reactive nonstress test consists of at least three movements by the baby within a 15 - 20 minute period, and each of the movements causes the fetal heart rate to increase with an acceleration of 15 - 20 beats per minute.

33. Any reasonably competent obstetrician should conclude, after approximately 80 - 90 continuous minutes of poor to absent beat-to-beat variability in a patient in labor, and after ruling out other causes of poor to absent beat-to-beat variability, that the baby is either in jeopardy, is sick or is otherwise not well, and should be delivered immediately by Cesarean section.

34. It is not difficult to read a fetal monitor strip where a fetus is brain dead. There is usually a wandering baseline for a brain dead fetus. Any reasonably competent obstetrician should be able to recognize the difference between a wandering base line and reflexive beat-to-beat variability.

36. Any reasonably competent obstetrician should be able to interpret a wandering baseline in a brain dead fetus and not confuse them with real accelerations and decelerations.

37. Any reasonably competent obstetrician should be able to recognize poor beat-to-beat variability.

38. Poor beat-to-beat variability indicates fetal distress.

39. Where there is poor beat-to-beat variability showing on the monitor strips for about 80 to 90 minutes from a fetus with normal brain activity, the standard of care is to stimulate the fetal scalp, to try to invoke a reaction from the fetus which would show on the monitor strip. If variability is not provoked, immediate Cesarean delivery should be

considered.

41. Poor beat-to-beat variability is one factor which should be taken into account when deciding if a Cesarean section should be performed. Other factors include how long the patient has been carrying the baby, the presence of meconium, the lack of accelerations, and a fetal heart rate tracing showing substantial numbers of variable and late decelerations.

42. Passage of thick meconium is not in and of itself an indicator of fetal distress. Passage of thick meconium, however, is an indicator of fetal distress in a patient who is past her due date, when there is poor beat-to-beat variability, lack of accelerations, and fetal heart tracings showing substantial numbers of variable and late decelerations.

45. The standard of care for delivery of a baby which is at 42 4/7 weeks gestation, has no reassuring accelerations and whose fetal heart tracings show substantial numbers of variable and late decelerations, poor beat-to-beat variability for 80 to 90 minutes, and thick meconium, is to perform a Cesarean section immediately.

53. The Board does not adopt this finding. Whether the baby would have died if delivered earlier was not the issue in the case. Had it been an issue, additional evidence would have had to be taken before a reliable finding of fact could be made.

76. There were no accelerations which a competent obstetrician would identify as reassuring in this case.

77. During the time Patient A was in labor and under the Respondent's direct care, there were also indicators on the fetal monitor strip that any reasonably

competent obstetrician could interpret as variable decelerations at approximately 12:40 pm, between 1:00 and 1:30 pm, 1:40 pm, 1:50 pm, 2:10 pm-2:20 pm, 2:40 pm-2:50 pm, 3:00 pm-3:10 pm, 3:30 pm, 3:50 pm, 4:00 pm, 4:05 pm, 4:20 pm, 4:30 pm, 4:50 pm, 5:00 pm-5:30 pm, 5:40 pm-5:50 pm, 6:00 pm, 6:10 pm, 6:20 pm and 6:40 pm.

78. During the time Patient A was in labor and under the Respondent's direct care, there were also indicators on the fetal monitor strip that any reasonably competent obstetrician could interpret as late decelerations at approximately 1:52 pm; 4:00 pm; 4:20 pm; 4:50 pm; 5:40 pm; 6:10 pm; and 6:30 - 6:40 pm.

80. The Respondent decided to have dinner. At the time he left for dinner, (6:45 pm), any reasonably competent obstetrician should have identified the presence of multiple decelerations on the fetal monitoring strip, particularly at 5:40 pm, 6:10 pm, and 6:30 - 6:40 pm.

82. Once the Respondent checked out for dinner, and Patient A was under the direct care of the chief resident, any reasonably competent obstetrician should have been able to interpret the fetal monitor strip as follows: 6:50 pm several repetitive late decelerations; 7:00 pm several repetitive late decelerations; 7:05 - 7:10 pm late decelerations with some variables; 7:20 pm variable decelerations followed by late decelerations, then bradycardia (the fetal heart rate crashing from 120 to 90, then even lower).

86. The delivery of the baby did not improve the baby's condition, and his condition further deteriorated rapidly after his birth; in approximately ninety minutes following birth, the baby's Ph worsened from 6.9 to 6.7 (7.2 being the lowest possible

for a well baby) and his CO_2 readings lowered to 22 (40 being the average for a well baby).

The Proposed Decision is attached as Appendix A.

CONCLUSIONS OF LAW

The Board has found the above Findings of Fact by clear and convincing evidence. Based upon those facts, a majority of the full authorized membership of the Board, by the unanimous vote of all Board members present, concludes that Respondent violated HO §14-404(a)(22) of the Maryland Medical Practice Act for failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care.

OPINION

The Board rejected many of the Administrative Law Judge's Proposed Findings of Fact. The rejection was based on the fact that many of those proposed findings were contrary to common medical knowledge, that the ALJ's reasons for choosing one expert over the other was not valid, and that she has accepted the concept of a new and lower standard of care for a certain group of physicians -- a concept with which the Board vehemently disagrees.

Weight of Expert Testimony

The Board rejects the conclusion of the ALJ that greater weight is to be given to the testimony of Respondent's expert based on his curriculum vitae. The Board has reviewed the entire record and concludes that the Administrative Prosecutor's expert, Dr. Kfoury, and the Respondent's expert, Dr. Clark, are equally qualified. Both possess

experience in peer review of obstetric cases. Both are board certified in obstetrics and gynecology and both are specialists in fetal heart monitoring.

Dr. Clark, Respondent's expert, testified that there is a separate standard of care for the "community based obstetrician." The Board rejects the concept of this separate (and lower) standard of care. The Board has never excused physicians from keeping up with current standards in medicine simply because they work in the community. On the contrary, the Board has always required even the most rural of physicians to be as competent as a physician connected with any of the many teaching hospitals throughout Maryland. Especially in a location like GBMC, where this case took place, which is minutes from two prestigious medical schools, there is no excuse for any physician not to be current in the teachings within his or her particular specialty. In any case, the Board rejects any findings which relate to a lower standard for a "community based obstetrician" and has modified the language of any finding of fact that referred to this standard.

Variability

The ALJ concluded that "the unusual pattern of poor beat-to-beat variability confused the Respondent." (Recommended Decision, p. 23.) The ALJ also agreed with the peer reviewers that Respondent did not realize the seriousness of the situation. The ALJ then concluded that Respondent's lack of realization of the seriousness of the situation can be explained away by Dr. Clark's theory of the "community-based obstetrician." The Board rejects that conclusion. The ALJ also concluded that there were apparent accelerations on the fetal monitor strip. The Board has carefully

reviewed this strip, and has determined that there were no reassuring or normal accelerations *during the entire monitoring period.*[1]

The Board is also concerned with the ALJ's comprehension of the peer review report. The ALJ criticizes that passage of the peer review report quoted below:

> It was plain that this baby was in trouble from the very beginning, yet [the Respondent] would have waited two hours. The standard would have been to repeat the monitoring in ten minutes to see if the beat to beat variability goes down or up.

The ALJ stated with respect to that comment, "the patient, however was in fact monitored from the time she arrived at GBMC.... Why the Committee suggested repeating the monitoring in 10 minutes is unclear."

This comment shows the Board that the ALJ did not fully understand the concept *of monitoring. The Board interprets the quotation from the Peer Review Committee's* report to mean that an obstetrician should check the ongoing monitoring every ten minutes in order to decide which action to take. The ALJ's misunderstanding of this simple concept of checking the fetal heart monitor caused the Board to be especially vigilant when reviewing the findings of fact of the ALJ on all medical issues.

The Board rejects the idea that the Respondent could not be held to a standard of knowledge to have interpreted the poor to absent beat-to-beat variability as such; the Board also rejects the idea that the Respondent would have been practicing within the standard of care to have interpreted this as variable accelerations. The

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[1]Dr.Sharma, at his exceptions hearing before the Board, admitted that there were no accelerations on the fetal monitor strip.

Respondent failed to meet the standard of care in the treatment of this patient with respect to the interpretation of the fetal monitoring.

Any reasonably competent obstetrician should be able to interpret a fetal heart monitor and a tracing of the type encountered in this case. But, even if Respondent could not interpret it for any reason, then the standard of care would require him to consult immediately with a fetal heart specialist or a perinatologist within the hospital or elsewhere. There is no evidence that Respondent consulted with a perinatologist at GBMC or elsewhere.

The Board rejects the ALJ's determination that "where the fetal brain is nonfunctioning, however, the monitor tracings are incredibly difficult to interpret." (ALJ Recommended Decision, p. 24) The Board concludes that an obstetrician must take into consideration whether the patient is predisposed to high risk when interpreting fetal heart monitors. In this case, the patient was two and 4/7 weeks past due, she passed meconium upon rupture of the membranes, there was poor to absent beat-to-beat variability, and there were variable and late decelerations. When all of these factors are taken into account along with the reading of Patient A's fetal heart monitoring strip, Respondent should have known that the baby's life was in danger.

Respondent should have been able to identify that there was unmistakable evidence of fetal or maternal jeopardy. The Board does not doubt that when a post-term fetus with meconium passage is being monitored on a fetal heart monitor, as long as the monitor shows normal accelerations, the obstetrician can be reassured regarding the well being of the fetus during labor. The problem with this case, however, is that

there were no normal or reassuring accelerations. As Dr. Kfoury testified, any accelarations on the strip were either compensatory accelerations, or accelerations which could not be interpreted as reassuring. Any competent obstetrician would recognize either type as an ominous sign for the baby.

There were no reassuring signs during the entire fetal heart monitoring process. Any competent obstetrician, considering that information together with the other factors present, including post-term status, presence of thick meconium in the membranes, variable and late decelerations, and absent to poor beat-to-beat variability, should have recognized, after 80 to 90 minutes of monitoring without any reassuring signs, that an immediate Cesarean section was warranted in this case.

Pitocin

The Board rejects the ALJ's opinion with respect to the use of Pitocin. Dr. Kfoury's testimony most accurately described the appropriate use of Pitocin: that if the fetus is depressed, administration of Pitocin will further compromise the fetus by decreasing its blood supply. Administration of Pitocin in this situation is not within the standard of care. Any reasonably competent obstetrician could have determined that the lack of reassuring signs of fetal well-being in Patient A contraindicated the use of Pitocin.

Fetal Sampling/Stimulation

The Board rejects the ALJ's opinion with regard to the failure to perform fetal sampling or stimulation. The Board holds that, after hydrating the patient and turning her on her side, with no reassuring signs from the fetal heart monitor, the standard of

care is that the Respondent should have performed fetal sampling or stimulation. Even when the patient is a tight 3 to 4 centimeters dilated, as in this case, it is possible for the obstetrician to perform this test. In this case, Respondent should have performed this test to determine whether the baby should be delivered.

Epidural

The Board accepts the ALJ's opinion with respect to administration of the epidural. The Board determines that, though the use of epidural could decrease the beat-to-beat variability, it was probably within the standard of care to administer an epidural to Patient A. This determination is based on the fact that a Cesarean section may have called for that type of anesthesia. In fact, this anesthesia enabled Dr. Rosenstein to perform an emergency Cesarean section.

Leaving for Dinner

Dr. Sharma's leaving for dinner, in the face of all the ominous signs of fetal distress discussed above, showed a lack of awareness which was below the standard of care. He should have performed a Cesarean section within 90 minutes of her entering the hospital, and should have noticed the especially ominous signs of fetal distress at 6:20 and 6:40 pm. The standard of care prohibits the signing out for dinner in these circumstances.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 3rd day of ~~November~~ December, 1997, by a majority of the full authorized membership of the Board

ORDERED that Respondent, Sheo P. Sharma, M.D., is hereby **REPRIMANDED**;

and it is further

ORDERED that Respondent be placed on **PROBATION** for a period of one (1) year, subject to the following condition:

1. That Respondent successfully complete a course on fetal monitoring approved by the Board.

ORDERED that Respondent's practice be peer reviewed after one year with the focus of the peer review to be on fetal monitoring and the appropriate response to signs of fetal distress; and it is further

ORDERED that if the Respondent fails to comply with any of the terms or conditions set forth above, then his failure shall be deemed a violation of this Order; and be it further

ORDERED that if the Respondent violates any of the terms of this Order, the Board, after notice and a hearing, and a determination of violation by a preponderance of the evidence, may impose any other disciplinary sanctions it deems appropriate, including reprimand, probation, suspension and/or revocation; and be it further

ORDERED that the Respondent is responsible for all costs incurred under this Order; and be it further

ORDERED that this is a Final Order of the Board of Physician Quality Assurance, and, as such, is a **PUBLIC DOCUMENT** pursuant to Maryland State Gov't Code Ann. §§ 10-610 et seq. and is reportable to both the Federation of State Medical Boards and the National Practitioner's Data Bank.

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occupations Code Ann. §14-408, Respondent has the right to take a direct judicial appeal. Any appeal shall be made as provided for judicial review of a final decision in the Administrative Procedure Act, State Government Article and Title 7, Chapter 200 of the Maryland Rules of Procedure.

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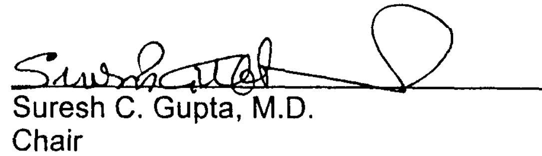
Date



Suresh C. Gupta, M.D.
Chair