Before the
New Hampshire Board of Medicine
Concord, New Hampshire

In the Matter of: **Docket #: 12-07**
Ashish Chaudhari, M.D.
License No.: 11302
(Adjudicatory/Disciplinary Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding in the matter of Ashish Chaudhari, M.D. ("Respondent" or "Dr. Chaudhari").

Background Information
(Procedural History and Motions)

As a result of notification on July 2, 2010 of a Writ of Summons filed in Merrimack County Superior Court, by a patient, J.M., against Dr. Chaudhari, the Board commenced an investigation pursuant to RSA 329:17, VI(c) and (d) to determine whether the Respondent committed professional misconduct with regard to J.M.. In pertinent part, the Writ alleged that Respondent provided inadequate care to J.M. by failing to timely diagnose or provide treatment for J.M.'s endometritis.

The case was assigned for investigation to the Medical Review Subcommittee ("MRSC") on September 16, 2010. After an initial investigation, additional materials were obtained which commenced a further review on July 20, 2011. The review was completed on September 15, 2011. The Board, once again returned the case to the MRSC for additional information on December 15, 2011. The MRSC reviewed the case on January 19, 2012 and forwarded it to the Board on February 1, 2012 with a recommendation that Dr. Chaudhari be disciplined. On February 2, 2012 the matter was referred by the Board to the Administrative Prosecution Unit of the Attorney General's Office for discipline on an allegation of inadequate postpartum care.

On June 8, 2012, the Board issued a Notice of Hearing, scheduling a hearing for December 5, 2012. On November 29, 2012, the Presiding Officer granted an assented-to motion to continue the hearing and ruled the hearing be rescheduled at a later date. On January 9, 2013,

the Board rescheduled the hearing for August 7, 2013. On March 6, 2013, the Board approved *Respondent's Motion to Continue August 7, 2013 Hearing* and scheduled the hearing for October 2, 2013. The hearing was held at the Board's offices on October 2, 2013, commencing at 1:00 p.m., in which the specific issues to be determined included, but were not limited to, the following:

A. Whether on or about April 26, 2009, Respondent engaged in professional misconduct by failing to admit or examine the patient when she presented to the emergency room with complaints of fever and severe abdominal pain, a pulse of 141, and labs of 87% bands, BUN of 28, and creatinine of 1.3, in violation of RSA 329:17, VI(c) and/or RSA 329:17, VI(d); and/or

B. Whether on or about April 26, 2009, Respondent engaged in professional misconduct by providing inadequate care to the patient due, in part, to his failure to recognize sepsis, in violation of RSA 329:17, VI(d); and/or

C. Whether on or about April 26, 2009, Respondent engaged in professional misconduct by failing to see the patient on the following day, despite having advised emergency room staff that he would do so, in violation of RSA 329:17, VI(c) and/or RSA 329:17, VI(d); and/or

D. If any of the above allegations are proven, whether and to what extent Respondent should be subjected to one or more of the disciplinary sanctions authorized by RSA 329:17, VII.

The members present included:

Mark Sullivan, P.A., Board President
John Wheeler, D.O., Board Vice President[1]
Robert J. Andelman, M.D., Physician Member, Presiding Officer
Amy Feitelson, M.D., Physician Member
Robert M. Vidaver, M.D., DHHS Commissioner's Designee
Daniel Morrissey, Public Member
Gail Barba, Public Member

The prosecution was represented by Hearing Counsel Senior Assistant Attorney General Jeffrey Cahill of the Administrative Prosecutions Unit ("APU") in the Office of the Attorney

[1] Dr. Wheeler left the hearing before it ended and therefore was not able to participate in the deliberations and the final vote. The remaining six members deliberated and voted on this Final Decision and Order.

General. The Respondent was represented by Peter A. Meyer, Esq., of Sulloway & Hollis, PLLC.

Respondent filed a *Motion to Excuse Robert P. Cervenka, M.D. as a Witness,* on September 30, 2013. The Motion was heard before the Board on October 2, 2013. Both parties presented oral argument and thereafter the presiding officer denied the Motion, finding simply because the expert witness being presented, Dr. Cervenka, was a member of the MRSC and known to the Board members was not in itself disqualifying. The presiding officer recognized that the fact that Dr. Cervenka was known to the Board could cut both ways as to issues of credibility.

The following exhibits were introduced into evidence upon stipulation by the Parties and accepted into the record:

1. Concord Hospital ER Records: April 26 & April 28, 2009

1A. ER Reports of Daniel Tzizik, P.A.: April 26, 2009

1B. Patient Laboratory Results: April 26, 2009

1C. Patient Discharge Instructions: April 26, 2009

1D Concord Hospital ER Report: April 28, 2009

2A. Dr. Chaudhari Office Note: April 27, 2009

2B. Dr. Chaudhari Office Note: April 29, 2009

3. Patient Ultrasound Report: April 27, 2009

4. Concord Birth & Wellness Records/Notes: April 23 - May 6, 2009

5. Dr. Chaudhari Written Response to Board Investigation: August 19, 2010

6. Mr. Tzizik Written Response to Board Investigation (undated)

7. Dr. Kay Written Response to Board Investigation: November 17, 2010

8. Patient Deposition Excerpt: February 14, 2010

9. CMC Records: April 28 – 30, 2009

10. CMC Records: May 1, 2009

A. Ashish Chaudhari, M.D.'s Curriculum Vitae

B. Ashish Chaudhari, M.D.'s Continuing Medical Education documentation

C. Thomas Connolly, M.D.'s Curriculum Vitae

D. Medical Records for J.M.

Also submitted at the close of the oral testimony on October 2, 2013, were written remarks entitled, *Closing Remarks on Behalf of Dr. Ashish Chaudhari* and *Respondent's Request for Findings of Fact and Rulings of Law.*

Daniel M. Tzizik, P.A., an ER Physician Assistant from Concord Hospital testified for Hearing Counsel. The Board found Mr. Tzizik to be forthright and credible.

Robert Cervenka, M.D., a board certified OB/GYN currently practicing at York Hospital in York, Maine, also testified for Hearing Counsel. Dr. Cervenka is an expert in Obstetrics and Gynecology. Dr. Cervenka testified as to the results of the investigation, and provided his medical opinions using a reasonable degree of medical certainty regarding the allegations set forth in the Notice of Hearing dated June 8, 2012. The Board found Dr. Cervenka to be direct, forthright and credible. The Board further found Dr. Cervenka to be articulate, candid and persuasive.

Thomas Connolly, M.D., an OB/GYN physician from New England OB/GYN Associates, testified on behalf of Dr. Chaudhari. Dr. Connolly is an expert in Obstetrics and Gynecology. The Board, likewise, found Dr. Connolly to be direct, forthright and credible. The Board further found Dr. Connolly to be articulate and candid.

The Respondent, Ashish Chaudhari, M.D., a board certified OB/GYN, founding partner and currently practicing at Concord's Women's Care, P.C., testified on his own behalf. The Board found Dr. Chaudhari to be direct, forthright and credible. The Board also found that Dr. Chaudhari is a well-qualified physician.

Synopsis of Facts

In light of the testimony and evidence as presented by both parties, the Board finds the following facts:

On April 26, 2009, J.M., a woman who was four days postpartum, after delivering her child by home birth, and complaining of abdominal pain, presented at the Concord Hospital Emergency Room. Daniel Tzizik, P.A. was working that evening in the Emergency Room and Dr. Kay was his supervising physician. A review of J.M.'s medical record from that evening

revealed that when Mr. Tzizik first saw her, "she looked slightly anxious, but was not in any acute distress." Mr. Tzizik gathered a history from her, did a physical exam, spoke with his supervising physician about the case several times, gathered some objective data, and then initiated two calls to Dr. Chaudhari, the "on-call" or "service OB/GYN" for the ER, and thereafter instituted a plan of care.

At the time he made the first call to Dr. Chaudhari, Mr. Tzizik knew that J.M. had lower abdominal pain, had an elevated pulse and that the patient had noted a fever at home of 101 to 102. Mr. Tzizik, at the request of the patient, abstained from performing a pelvic exam. After only discussing the patient on the phone with Mr. Tzizik, Dr. Chaudhari, advised Mr. Tzizik to have J.M. use a nonsteroidal anti-inflammatory, something for her pain, and that he would not suggest antibiotics or an emergent ultrasound at that time but that he wanted her to follow up in his office tomorrow.

Mr. Tzizik then received lab results for J.M. which showed a "neutrophil count of 8 percent, band cells of 87 percent and absolute neutrophils of 11.2, with some metamyelocytes and myelocytes as well." In addition, J.M. had a BUN of 28 which could be consistent with some mild dehydration. After obtaining this information, Mr. Tzizik again called Dr. Chaudhari for the second time and spoke with him about antibiotic therapy given the laboratory results. Dr. Chaudhari told Mr. Tzizik that at the time he did not want to treat J.M. with antibiotics. As such, Mr. Tzizik instructed J.M. to use vicodin for her pain, and that she should return if acutely worse, fevers, or vomiting and should follow up with Dr. Chaudhari the next day.

The testimony and evidence revealed that when J.M. left the hospital that night she was instructed to call Dr. Chaudhari's office in the morning for an appointment. Mr. Tzizik testified he understood J.M. would have an appointment with Dr. Chaudhari at his office the next day and that he had no reason to believe the appointment would be conditional. According to Mr. Tzizik, J.M.'s laboratory results revealed a sodium of 129, a potassium of 3.2, a chloride of 101, a glucose of 82 and a bicarb of 20; all of which, except the glucose, were abnormal. Mr. Tzizik's testimony revealed that a bicarb of 20 meant she was mildly acidotic. Additionally, according to Mr. Tzizik, a patient with 87 percent bands with myelocytes and metamyelocytes means that there is a possible infection. In fact, Mr. Tzizik testified that there was a probable infection given the blood test results.

Dr. Robert Cervenka, a board certified OB/GYN testified that as a member of the MRSC he reviewed medical records in 2010 and prepared a report to present to the MRSC concerning this matter. At some point, he learned that there were additional records from Concord Hospital which he had not reviewed; and after obtaining them, subsequently filed a supplemental report with the MRSC in December 2012. According to Dr. Cervenka, based on the review of the medical records, J.M. delivered her child in an uncomplicated at home birth with the assistance of a lay midwife on April 22, 2009. The lay mid wife continued her routine care of J.M. after delivery. On April 24, 2009, J.M. called the midwife to report a fever of 102 and uterine cramping. In a phone call the following afternoon, J.M. reported extreme uterine pain and a fever of 101 degrees. On the fourth day, postpartum, where J.M. still reported severe uterine pain, the lay midwife recommended that J.M. report into the emergency room. Dr. Cervenka's testimony revealed that on the evening of April 26, 2009, J.M. went to Concord Hospital emergency room and that J.M. complained of fever, and abdominal pain, which she rated as an eight out of ten that was not helped by Tylenol with codeine. Dr. Cervenka testified that various parts of J.M.'s medical records showed a pulse of 148, another of 141 and a handwritten note indicating either 100 or 160. The evidence revealed that J.M. had tenderness in the area of her uterus, ostensibly causing her to decline a pelvic examination as well as her being worried about her stitches.

Dr. Cervenka provided his medical opinion regarding the lab results, as discussed by Mr. Tzizik, and indicated J.M. was experiencing what is known as a "shift to the left" which is where one's bone marrow is being mobilized to fight infection.

According to the medical records that Dr. Cervenka reviewed, J.M. did not have a fever at the hospital that night but she reported one of 102 at home. He indicated that absence of a fever in the ER or the white count alone may not mean much; but Dr. Cervenka testified that the bigger picture of the laboratory results, her tachycardia, and the fast respiratory rate all were "crystal-clear evidence of infection." Dr. Cervenka additionally indicated that the records revealed J.M. had a creatinine of 1.3, which even for someone who had just delivered a child was markedly elevated, and a BUN of 28. J.M.'s creatinine was suggestive that she was dehydrated. Additionally, she had a CO2 level of 20 which is a very low number and a pulse of 141. To Dr. Cervenka, all of this information indicated that she was fighting a very serious infection. He further averred that he would have started this patient on antibiotics over the phone and then would have come in to see the patient.

Dr. Cervenka further testified that a review of this patient's medical records revealed there was a plan for J.M. to follow up with a visit to Dr. Chaudhari the next day. He noted, however, J.M. did not make the office visit to Dr. Chaudhari on the morning of April 27th because when she called his office, J.M. reported she was told that since she did not have a fever of 101 she should not come in.

Instead, the medical records reveal on April 28th, 6 days postpartum, J.M. visited the Concord Hospital, walk-in urgent care at Horseshoe Pond, and met with a Dr. Connor. . Dr. Connor recommended that she go to the Concord Hospital Emergency Room for further work-up as the walk-in clinic was not able to handle her situation, given his belief J.M. needed additional labs, a possible imaging and possible IV antibiotics. The April 28th, Walk-In Care note reflects, however, that J.M. was "somewhat reticent" to return to the Concord Hospital ER. Dr. Connor, nonetheless, recommended that J.M.'s husband take her to the Emergency Room.

The evidence reveals that J.M traveled to Catholic Medical Center to be seen in their ER. With lab results that were very similar to the ones on April 26th at Concord Hospital, Catholic Medical Center admitted J.M. and she received antibiotics for about 48 hours before being discharged with a subsequent readmission two days later. When J.M. was admitted to Catholic Medical Center on May 1, she had a fever of 102, a white blood count of 32.11, 88 polys, 3 bands, 3 metamyelocytes, thus revealing 94 percent infection-fighting cells. By that time there was massive ascites in the abdomen, and peritonitis. According to the medical records, as testified to by Dr. Cervenka, J.M. was admitted to the ICU and transferred to the Dartmouth-Hitchcock Medical Center (DHMC) where she underwent surgery for a total abdominal hysterectomy and bilateral salpingo-oophorectomy; i.e. to have her uterus, tubes and ovaries removed due to pelvic abscesses.

In Dr. Cervenka's medical opinion, the patient's infection could have been taken care of and the subsequent medical problems avoided had her infection been treated on April 26 or 27. Dr. Cervenka was confident that the infection was confined to the endometrium and myometrium, and with no evidence of abscessperitonitis, or that the infection had spread to the point of requiring surgical intervention. It was Dr. Cervenka's opinion that the problem of April 26 would have been much more likely than not been adequately treated solely with antibiotics.

Dr. Cervenka testified that there were several ways to handle treatment of J.M. on the first evening in Concord; all of them involving antibiotic initiation, whether the doctor admits the

patient to the hospital or not. In addition, it is Dr. Cervenka's medical opinion that J.M. met all the criteria for endometritis and she was ignored by Dr. Chaudhari where he did not see the patient within a 24 hour period, given his status as the on-call OB/GYN in the emergency room. Dr. Cervenka testified that the decision not to report to the Emergency Room, given the information obtained in the second phone call amounts to an absence of care. Likewise, his opinion relating to the decision not to see J.M. the next day at Dr. Chaudhari's office also amounted to an absence of care.

Dr. Thomas Connolly, a board certified OB/GYN from Massachusetts, testified on behalf of Respondent. Dr. Connolly was asked by Respondent to review the record in this case and determine if Dr. Chaudhari met the standard of care. Based on what Dr. Chaudhari was told on the phone, it was Dr. Connolly's medical opinion that Dr. Chaudhari met the standard of care in the way that he handled the situation when he did not come in to see J.M. on the evening of April 26th, 2009. Dr. Connolly saw nothing in the medical record indicating that Dr. Chaudhari was asked to physically observe the patient on the evening of April 26, 2009.

Dr. Connolly also testified that Dr. Chaudhari met the standard of care in the manner in which he handled the situation when J.M. called the office on the morning of April 27, 2009, where she did not have a fever, and was told to see her primary obstetrical provider. He testified that based on his review of the medical records in this case, the situation "did not seem to be" an emergency on the night of April 26th. Dr. Connolly, did testify in his expert medical opinion, the bandemia was "worrisome" and the "pulse was worrisome too" "[b]ut from [his] understanding, Dr. Chaudhari wasn't given the information about the tachycardia." Dr. Connolly testified that it was reasonable for Dr. Chaudhari to not physically report to the emergency room to treat J.M. and to not order antibiotics that night. Dr. Connolly also testified that Dr. Chaudhari's approach with J.M. on the morning of April 27th was likewise reasonable.

Dr. Chaudhari, a board certified OB/GYN and the Respondent in this matter, testified on his own behalf at the October 2nd hearing. Dr. Chaudhari testified that at a minimum he has served as the on-call OB/GYN for the hospital emergency department probably ten times per year over the last 10 years. He indicated he has never declined to come see a patient. He did not decline to see J.M. because the ER doctor and ER P.A. did not ask him to come in. Dr. Chaudhari testified that he gets along very well with both the ER doctor and the ER P.A., he

often consults with them and they trust one another's judgment. He further testified that this particular night was a formal consultation with phone calls because he was the service doctor.

Dr. Chaudhari revealed through testimony that based on the information that Mr. Tzizik provided him during the first phone call, his opinion was that it was not an emergency situation. He suggested, that the second telephone conversation included the discussion of bandemia and he was concerned about infection but he was not sure where. He revealed that he was also aware that J.M.'s urine was dirty or contaminated and while it was "cooking" he did not know what he would be treating, so where his teaching said don't treat something you don't know – he did not want to make things worse. Dr. Chaudhari noted it was his conclusion that the people who were evaluating her over the last 6 to 7 months should re-evaluate her and see what was going on. Dr. Chaudhari contended he did not know about the tachycardia at the time of the second phone call. He says that he disagrees that Mr. Tzizik told him about the tachycardia, because something that significant would not have escaped his ears. Dr. Chaudhari, however, had testified at a previous deposition that while he does not recall being told about the tachycardia, he would have no reason to disagree with Mr. Tzizik if Mr. Tzizik recalled informing Dr. Chaudhari of the tachycardia.

Dr. Chaudhari testified that on the morning of April 27, his office staff, likely a secretary, took a phone call from J.M., who reported to the office staff that she was having pelvic pain and did not currently have a fever. Dr. Chaudhari could only guess about a note in the file and that a nurse probably asked if J.M. had a fever greater than 101 degrees. He testified that the note revealed that he was questioned about the temperature and he said that J.M. should follow up with her midwife, but that she should be told that he would be happy to see her if her temperature went above 101. Further testimony by Dr. Chaudhari revealed that he believed J.M. should be seen by someone that knew her and that the midwife Jeannie Browne had called him to see her patients in the past, but she did not call him on J.M.

Dr. Chaudhari disagreed that he was grossly negligent in this case notwithstanding the testimony of Dr. Cervenka, as he made a clinical judgment, was never asked to come in, and J.M. was not febrile. He indicated he simply did not have the information to work with. Dr. Chaudhari admitted that he did not see J.M. on April 27, did not follow up with her and that this was a non-emergent situation. He contended that it was his job as the service doctor to take care of emergency OB/GYN issues that presented to the ER. He further testified that he did not

believe a physician-patient relationship existed with J.M. Testimony did, however, reveal that at the time Dr. Chaudhari received the phone calls from Mr. Tzizik on the evening of April 26, Dr. Chaudhari was already in the hospital, in the call room.

Analysis and Rulings of Law

The question of the treatment plan and decision on whether to admit J.M. on the evening of April 26, 2009 is one that involves analyzing the standard of care that should be utilized by a board certified OB/GYN where a patient who is 4 days postpartum presents to the emergency room complaining of severe abdominal/pelvic pain and where the objective data reveals bandemia, abnormal lab results, and an elevated white blood count. Based on the credible testimony of Dr. Cervenka we find that the failure to independently observe the patient and then refusing to see her the following day, constitutes an absence of care, demonstrating a medical practice which is incompatible with the expectations of those physicians specializing in OB/GYN. The Board accepts and finds credible the testimony of Dr. Cervenka when he testified the failure to see the patient on April 27, after the events of the evening before, constitutes the absence of care and amounts an extreme departure of ordinary care.

Upon leaving the emergency room the night before, Dr. Chaudhari had agreed to see J.M. the next day at his office. When he then refused indicating J.M. should follow-up with her mid-wife, that was an absence of care, incompatible with the competence expected of a board certified OB/GYN, and an extreme departure from the expectations of a reasonable provider. First, as a matter of fact the record reveals, Dr. Chaudhari was the on-call physician responsible for consulting on OB/GYN patients that were at the emergency room seeking treatment. He was called on two occasions during the unassigned patient's stay in the emergency room and participated in an attempt to diagnose and treat J.M., the patient. The discharge instructions show that Dr. Chaudhari agreed to follow-up with the patient the next morning. These facts establish the existence of physician-patient relationship. Moreover, the emergency room called Dr. Chaudhari days later to inform him that the urine culture was positive and Dr. Chaudhari, based on that, attempted to contact the patient, who by that time was already admitted to Catholic Medical Center. Dr. Chaudhari's involvement was more than simply providing advice to a

colleague. Next, Dr. Chaudhari's sole reliance on temperature[2] for his decision not to see the patient denotes an indifference to the duty he had when she called his office as instructed, where he did not ascertain any information about the continued nature of the symptoms that brought her to the emergency room in the first instance. Simply saying – call someone else – is inappropriate and establishes extreme indifference to care. Dr. Chaudhari had established a physician-patient relationship with J.M. when he made the commitment to observe her and he had an ethical obligation to see her the next day.

Dr. Connolly disagreed with Dr. Cervenka's opinion that Dr. Chaudhari's conduct on the morning of April 27th was gross negligence. While Dr. Cervenka believed on April 27th that Dr. Chaudhari failed to act and that there was an absence of care, Dr. Connolly testified that was not the case and that Dr. Chaudhari tried to track down the patient after he got her urine culture back that was positive. Dr. Connolly admitted that if Dr. Chaudhari were aware of the tachycardia on the night of April 26th, "it creates a more worrisome situation, the tachycardia" … and specifically worrisome for indications of infection. Dr. Chaudhari also disagrees with Dr. Cervenka's assertion that his conduct on April 26th or 27th was gross negligence. Dr. Chaudhari asserts that he made a clinical decision based on the information that was given to him. He states that neither Dr. Kay nor Mr. Tzizik asked him to come in. Given the information he had, he decided it was a non-emergent situation, he asserts that by the time he had sufficient information he acted where he phoned J.M. to tell her about her positive urine culture.

The Board realizes that complex clinical situations may become clear only in hindsight. The Board, however, accepts as more credible the testimony of Dr. Cervenka that a WBC of 11,800 with the massive left shift is evidence of a serious if not overwhelming infection. Both Dr. Chaudhari and Dr. Connolly admitted in response to questioning by a Board member that it is extremely unusual for them to see such a severe left shift.

The Board is also impressed that Mr. Tzizik's second call to Dr. Chaudhari was made specifically in order to communicate the highly abnormal differential of the white count, and that PA Tzizik specifically dictated a note documenting that call. The Board is also struck by the

[2] Temperature is only one diagnostic criterion. The larger picture, including the patient's refusal to have a pelvic exam, the lack of exam by an obstetric specialist, the extreme and unusual bandemia, the low serum bicarbonate, the elevated BUN and creatinine, and the clinical setting of abdominal pain days post-partum all must be taken into account.

fact, that during this Emergency Room visit by J.M., Dr. Chaudhari was, by his own admission, in the hospital on the Obstetrics suite, or in the call room, and could have left his patient.

Responding to the highly abnormal differential, indicating a massive infection, by walking from Obstetrics to the Emergency Department, to examine the patient and review the lab results would have negated the entire unfortunate outcome, and surgery more likely than not would have been avoided. In addition, the Board feels strongly, that when Dr. Chaudhari agreed to see the patient the next day, he was accepting responsibility for the patient's care, thus continuing a previously established physician-patient relationship.

The consultant, on "service-call" is responsible for the care of unassigned patients without a physician, whether those patients be uninsured, homeless, or penniless. The Board believes that the medical community is responsible for that crucial medical safety net, to these patients and that Dr. Chaudhari failed to provide that crucial net to this patient. While Dr. Chaudhari testified that he would absolutely have come to the emergency department if asked to do so, the fact that he did not because the emergency department never asked him does not excuse the failure especially in light of the emergency department's second contact informing him of the severe bandemia.

Since this incident, Dr. Chaudhari has done more medical education in the areas of infection in OB-GYN cases and he has voluntarily read and revised 30 or more articles on the issue. He has done various seminars and conferences all to better educate him since April 26-27, 2009.

The issue for this Board to decide is whether under the law in effect as of April 2009 that the Respondent engaged in professional misconduct pursuant to RSA 329:17 VI (c) and/or (d). :

RSA 329:17, VI states in pertinent part:

> The board, after hearing may take disciplinary action against any person licensed by it upon finding that the person: …
>
> (c) Has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof.
>
> (d) Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing medicine or in performing activities ancillary to the practice of medicine or any particular specialty thereof, or has intentionally injured a patient while practicing medicine or performing such ancillary activities.

RSA 329:17, VI (2009).

We find that Dr. Chaudhari's actions on April 26 and 27th do not rise to a violation under RSA 329:17, VI(c), as we cannot say there was a pattern of behavior in medical practice; where here the treatment or lack thereof was simply with one patient over multiple days. We cannot say by the evidence before us that Respondent engaged in a regular and repeated behavior when faced with the conditions he was presented. We do, however, find that the Respondent has engaged in unprofessional conduct and was grossly negligent with regard to J.M. We find that a reasonable provider in Respondent's field would not have ignored the severe bandemia. Respondent's own witness, Dr. Connolly, testified that the severe bandemia was worrisome. While he testified that he thought it was reasonable not to administer antibiotics, Dr. Connolly gave no explanation as to the propriety of actually visiting the patient, where Respondent was in the hospital at the time of the phone calls. We reject Dr. Connolly's opinion that Respondent met the standard of care on April 26th and 27th, 2009.

Dr. Chaudhari should have used the information provided to him by the Emergency Department P.A. to actually see J.M. in the Emergency Room; and by not seeing her that night and then declining to see her the next morning, Dr. Chaudhari's actions were more than inadvertent, they were extremely indifferent to the duty he owed. He took virtually no action which is tantamount to extreme indifference, which we find to be both grossly negligent and unprofessional conduct.

With regard to the submissions of findings of fact and rulings of law submitted by Respondent, the Board grants numbers 1, 5, 7, 14, 15, 17, 18, 19, and 20. The Board denies numbers 6, 9, 12, 16, 21, 24, and 36. The Board neither grants nor denies questions 25 through 34 as those questions relate to a pattern of conduct or repeated negligence, to which the Board has determined not to exist in this case. The Board finds "Other" for the remaining numbers either because the finding is not relevant to the proceedings (i.e. number 2); or the statements are not completely accurate and would be granted in part and denied in part (number 3, 4, 8, 10, 11, 13, 22, 23, and 35).

Disciplinary Action

After making its findings of fact and rulings of law, the Board deliberated on the appropriate disciplinary action. RSA 329:17, VII ("The board, upon making an affirmative finding under paragraph VI, may take disciplinary action in any one or more of the following ways…."). In these deliberations, the Board considered the mitigating factors that the

Respondent has been forthcoming and cooperative throughout the Board's investigation and was without previous matters before this Board, having not been disciplined before or since this instant matter. The Board also considered Respondent's decision to further his knowledge regarding infections and showing that he was invested in learning from the experience.

THEREFORE, IT IS ORDERED that the Respondent is REPRIMANDED;

IT IS FURTHER ORDERED that the Respondent meaningfully participate in 10 hours of continuing medical education in the areas of (a) infectious diseases and (b) medical ethics (including an understanding of what and how one defines a physician-patient relationship under NH law and practice). These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed within 6 months of the effective date of this Order. If Respondent has already completed coursework in the areas described above, Respondent may submit proof of completion of said courses as soon as possible and no later than three months from effective date of this Order. The Board will review the course outlines, and proof of Respondent's attendance at said courses if Respondent has completed any course work prior to issuance of this Order.

IT IS FURTHER ORDERED that this final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document.

IT IS FURTHER ORDERED that this Final Decision and Order shall take effect as an Order of the Board on the date that an authorized representative of the Board signs it.

*/BY ORDER OF THE BOARD

DATE: 3/11/2014

Penny Taylor

Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine

*Board Member, Louis Rosenthall, M.D., recused. Board Members, John H. Wheeler, D.O., Michael Barr, M.D., Emily R. Baker, M.D. and Edmund J. Waters, Jr., Public Member, not participating.