

APRIL 29, 1987

**NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS**STATE OF NEW JERSEY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS
DOCKET NUMBER _____IN THE MATTER OF
JOSEPH M. HASSMAN, D.O.
LICENSED TO PRACTICE MEDICINE
AND SURGERY IN THE STATE
OF NEW JERSEYAdministrative Action
ORDER REVOKING LICENSE

This matter was presented to the New Jersey State Board of Medical Examiners by the Attorney General of New Jersey, by Joan D. Gelber, Deputy Attorney General on inquiry following the entry on December 19, 1986 of a judgment of conviction against Dr. Hassman for the criminal offense of manslaughter in the second degree. Dr. Hassman is represented herein by Lewis Katz, Esq.

Dr. Hassman is engaged in the practice of family medicine at 106 South White Horse Pike, Berlin, New Jersey, and holds license number 21112. His background, as pertinent to the issues before us, includes representations that he has practiced with honor in his community for some 20 years, has privileges at several hospitals, and provides medical services at four nursing homes. He has actively participated in the affairs of the community, and for the past 15 years has served, without pay, as the medical director of a drug rehabilitation program for adolescents, a program of which he was a co-founder. Married for 31 years, he and his wife have four children; the three eldest have completed or are presently involved in medical training. He has encouraged his wife's pursuit of higher education as well. He is known for a particular devotion to members of his family, including specifically his mother-in-law, Mrs. Esther Davis. It is the death of Mrs. Davis that has precipitated this matter.

It appears that Mrs. Davis was a strong and active woman who,

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after Joseph Hassman's marriage to Lillian Davis, treated him as though he were her son, providing financial assistance and even living quarters during the early years of the Hassman marriage. Relations apparently continued to be very close thereafter, and when the Davises planned to retire after a long and hardworking life, Joseph Hassman made money available to them to help them afford a retirement home. During the late 1970s, Mrs. Davis began to develop strange behavior and illness which was ultimately diagnosed as Alzheimer's Disease. As is typical in that disease, her memory became erratic and deteriorated to the point where she no longer recognized those closest to her or previously familiar surroundings. Dr. Hassman is said to have provided much emotional support to her, to her husband (Dr. Hassman's father-in-law), to his wife and to the other members of the family. During this period, his own mother died a painful death from cancer. When Mrs. Davis' condition deteriorated to the point where she could not be cared for safely at home, she was admitted to the Linwood Convalescent Center, where she remained for 1 and 1/2 years until her death, visited regularly by Joseph Hassman and his wife.

Information has been made available to the Board from nursing home records, police reports, records of police interviews with nursing home personnel and with physicians treating Mrs. Davis and from Dr. Hassman himself. These records confirm that after some eight years of suffering with Alzheimer's, by early 1980 Mrs. Davis was unable to feed or clothe herself, and had no control at all over urine or bowel

movements. Her quality of health was described by her treating physician (not Dr. Hassman) as very low and with no chance for recovery. By early March 1986 the family was informed that Mrs. Davis' condition had deteriorated significantly. Review of the medical record for Mrs. Davis at the nursing home, supplemented with affidavits and reports gathered later by the police, reveal the following circumstances in the days prior to her death.

On April 5, the nursing staff realized that Mrs. Davis no longer had a gag reflex and she could not swallow. The nursing notes of that day also report blisters on the patient's body from her bedridden position, and the presence of moist-sounding respirations. The patient was unable to eat or to swallow medication. "Tongue appeared too big for mouth." The nursing staff notified Dr. Jonathan Slotaroff, who was covering for Mrs. Davis' regular physician, George Slotaroff, D.O. He surmised that Mrs. Davis had suffered another stroke and he advised that feeding be administered through a nasogastric tube in addition to hydration by means of an intravenous solution of saline, potassium and vitamins. The physician's progress notes for April 5 confirm the inability to swallow, the mucous-filled oral cavity, loss of gag reflex, swollen tongue and inability to speak. On the same day, April 5 (time not noted), Dr. Jonathan Slotaroff gave orders to discontinue Haldol (an antipsychotic drug) and to substitute Cogentin by mouth, to do frequent oropharyngeal suctioning, and if the patient was unable to swallow, then to pass a nasogastric tube. Mrs. Davis was suctioned many times by the nursing staff. This was described by Dr. Hassman as being necessary as often as every 15 minutes, while his 80-year

old mother-in-law lay in the bed with "her mouth open, her tongue hanging out." The Hassman and Davis family convened at the nursing home, and agreed that it was not in their mother's interests to be subjected to the further stress of a nasogastric tube or other "heroic measures."

It appears that Dr. Hassman telephoned Dr. Slotaroff on behalf of the family and requested that there be "no heroics" and no nasogastric tube. Dr. Slotaroff agreed with this request and at 4:30 p.m. the same day, he issued a no-code order.

The nursing notes of April 5 (4-12 midnight shift) appear to indicate that after the no-code order was issued, the nursing staff

"Tr[ie]d to insert nasogastric tube without success. Patient suctioned every two hours for large amount of mucous. No intake ...[of fluids] this shift. Patient unable to swallow. IV attempted at 10:30 without success. Veins very fragile. Ice applied. Patient resting at present. Dr. Slotaroff ordered IV. Patient does not appear dehydrated and color good."

Notwithstanding the family agreement and Dr. Slotaroff's concurrence with a limited treatment approach, Dr. Hassman states that the head nurse (believed to be Elmslie LeeAnne Schwiers, R.N.) approached him to contend that the nursing home "can't do nothing" [i.e. is required to do something affirmative] in such a circumstances and insisted that there must be at least an IV tube inserted. He says the family felt compelled to agree to this, and the nursing staff then attempted to begin this procedure.

This account seems to be confirmed by the nursing notes of April 5, which report that Mrs. Davis' daughter (Dr. Hassman's wife) called to inquire about her mother and the nurse explained

"the seriousness of inserting nasogastric tube. She (daughter) agreed to go the IV route, if necessary. Attempted three times without success. Suctioned frequently. Copious amounts thick, foamy white mucous. Patient is aware. Temperature 100.4 rectally. Pulse 104. respirations 32. blood pressure 136/90. P.O. fluids attempted with bulb syringe - coughing and having difficulty swallowing."

The nursing notes from 12 midnight to 8 a.m. continue, noting that the blistered body required still more treatment and

"oxygen started at 2 liters/minute for comfort. Seems unable to close mouth and tongue appears still swollen. Breathing easier with oxygen."

Later that day, the IV was started. The patient was suctioned frequently. Dr. Hassman states that Mrs. Davis kept pulling the IVs out, the nurses kept trying to reinsert them, and the patient's arms had to be restrained. Her arms became swollen from the repeated needle insertions. Dr. Hassman said the head nurse again approached him and insisted that the nursing home was obliged to do something: either to insert a nasogastric tube or send the patient to the hospital.*

It appears that another attempt for physician intervention was made by Dr. Hassman at that point. The nursing notes say "Daughter's husband who is a doctor spoke with Doctor Slotaroff re patient's condition and their wishes of patient not to have nasogastric tube were ordered [sic]." All oral medications and the nasogastric tube order were then

* We note that the recent case of In re Requena, 213 N.J. Super. 475 (Ch. Div. 1986), affirmed and supplemented at 213 N.J. Super. 443 (App. Div. 1986), suggests that in appropriate circumstances, a health care facility cannot eject a patient electing to receive only supportive care and no further medical treatment.

discontinued. Nursing notes of the patient show that thick white mucous was now observed to have a yellow tinge. Mrs. Davis' temperature was still elevated. Later that day, the IV had infiltrated and by evening had to be pulled out.

By April 7 thick yellow mucous was being suctioned. The patient was noted to be continually taking the oxygen device out of her nose. The IV was reinserted. By afternoon Mrs. Davis' temperature was still elevated and a neurological consult was ordered at the request of the family. The IV infiltrated again. Despite the problem clearly documented earlier on the same day shift regarding the patient's inability to swallow, the nursing notes indicate continued efforts to get the patient to swallow water and juice, which were reported as "taken with great difficulty in swallowing." The nurses found it necessary to suction the patient frequently and the patient was reported to be very restless. The same nursing events and observations occurred on April 8, including the effort to get the patient to swallow juice despite "much difficulty in swallowing." "Patient only restless when suctioning." Her temperature was still rising. The IV was "out" again and then restarted. Dr. Hassman was often present to observe the treatment afforded by the well-meaning nursing staff.

During this time, the family requested that a neurological consultation be done. Dr. Hassman states that a neurologist recommended by Mrs. Davis' former treating physician was rejected by the head nurse because he was "not on staff" at the nursing home. The nurse suggested consulting with Dr. Henry Greenwood, who declined to personally come to the nursing home. Therefore,

on April 8, Dr. Hassman made the financial arrangements necessary for Mrs. Davis to be transported to Shore Memorial Hospital where Dr. Greenwood performed a neurological examination and reported that the patient's inability to swallow was related to the advanced stage of her Alzheimer's Disease. The neurologist concluded that Mrs. Davis was unable to understand when spoken to, and was totally unable to communicate. He recommended "minimum supportive care" only and "no extraordinary means of support" and continuation of the IV solution because, neurologically, she was in a terminal condition with no likelihood of recovery. After the consultation, the patient's condition was reported in the nursing home record as "guarded." The neurologist is reported to have later offered to the police investigators his opinion that the quality of Mrs. Davis' life was "terrible."

Dr. Hassman says that upon their return to the nursing home, he informed the head nurse of the report, and that although Dr. Slotaroff agreed there should be no nasogastric tube inserted, the nursing home said something about a need to call the Ombudsman. Dr. Hassman asserts that he was not aware at that time of the Supreme Court's decision in the case of Matter of Conroy, 98 N.J. 321 (1985) and was not informed of the role the Ombudsman was expected to play in this matter. It appears that the Ombudsman was never actually contacted by the nursing home.

It was apparently at this time that Emslie (LeeAnne) Schwiers, R.N., concluded that the IV pump in use was not functioning properly. Nurse Schwiers, the Special Care Unit

Director and In-Service Coordinator, determined to remove the erratic IV pump and to install a new one. This was accomplished at about 3:45 p.m. on April 9, 1986. Dr. Hassman states that he himself assisted the nurse in assembling the machine. Nurse Schwiers then instructed another nurse to accompany her to Mrs. Davis' room so that at least one other nurse would be familiar with the pump procedure in the event that the second pump malfunctioned. On entering the patient's room, the nurses made several observations including the following: Mrs. Davis' husband was standing at the foot of the bed; Mrs. Davis' daughter was standing to one side, stroking her mother's arm and crying; Dr. Hassman was standing on the other side of Mrs. Davis' bed next to the IV apparatus, bending over her. It was further observed that the sheet which usually covered the IV site on Mrs. Davis' arm had been pulled down, exposing the IV site. When the nurse entered, Dr. Hassman pulled the sheet up and he placed on the IV pump a roll of tape of a size which the nurse believed was not previously present in the room. Dr. Hassman's account of this event is that he had observed air bubbles in the IV mechanism, and was manipulating the tube to dislodge them.

After the pump demonstration, the nurses left the room. Almost immediately after leaving, however, one of them expressed concern that the family might not realize how seriously ill Mrs. Davis was, and they returned to the room to ask Dr. Hassman to step outside for a word with them. He is reported to have indicated that the family was indeed aware of Mrs. Davis' condition, and if she were to die "suddenly", Mr. Davis could come and stay with the Hassmans. The family left the nursing home at about 4:30 p.m.

At about 4:55 p.m. other staff discovered Mrs. Davis to be without vital signs. Dr. Slotaroff noted on the record that there had been no intake of fluids by the patient by mouth, and that there had been progressive deterioration and then death. Nurse Schwiers informed administration personnel that she had made certain observations which caused her to suspect that the death of Mrs. Davis, only 25 minutes after Schwiers' last contact with her, was not natural. Police investigation followed.

Dr. Slotaroff was interviewed by the police, and informed them that the patient had had other strokes prior to this one. He offered his medical opinion that, without a nasogastric tube and IV hydration, Mrs. Davis would probably have died within 2-3 days, and with IV hydration alone, would have died within approximately one week.

An autopsy and toxicology study were done. The autopsy report disclosed "cerebral atrophy, bilateral frontal lobes, consistent with Alzheimer's Disease; occlusive atherosclerotic changes of the middle cerebral and anterior cerebral arteries, occlusive coronary atherosclerosis; patchy fibrosis of the myocardium; arteriolar nephrosclerosis; generalized atherosclerosis, moderate to marked; right lower lobe pneumonia." The toxicology report was not received until September 26, 1986. That report disclosed an injection site positive for meperidine and presence of meperidine in the stomach, liver, bile, blood and urine. Traces of another medication, Digoxin, were also reported to be found. Neither of these drugs had been on Mrs. Davis' medication orders. The Medical Examiner concluded that Mrs. Davis had died 25

minutes after being given an injection of meperidine (Demerol).

Suspicion focussed on Dr. Hassman. On November 20, 1986, accompanied by his attorney, he pleaded guilty to an Accusation of manslaughter under N.J.S.A. 2C:11-4, i.e. that he did "recklessly cause the death of Esther Davis, age 80." He waived indictment and trial by jury. An order for presentence investigation was issued the same day. Mr. Davis, father-in-law to Dr. Hassman, died one week prior to the sentencing. On December 19, 1986 the County Prosecutor requested that the Court accept a plea of manslaughter in the second degree with sentencing to be done as for a crime of the third (i.e., a lesser) degree. Dr. Hassman stated to the Court as follows:

"On April 9, when visiting my mother-in-law, Esther Davis, at the Linwood Convalescent Center, she was in great distress. Her condition was terminal. She had lost the ability to swallow, and was unable to know or recognize anyone. I was not her attending physician at the nursing home. I injected Demerol and Vistaril into her IV tubing, which hastened and caused her death."

After consideration of the circumstances, the Court entered a judgment of conviction placing Dr. Hassman on 2 years of probation, 200 hours of community service, a fine of \$7,500 and an assessment of \$2,500 to the V.C.C.B., and one day in jail as previously served.

N.J.S.A. 45:1-21(f) authorizes the State Board of Medical Examiners to take disciplinary action against a licensee who "has been convicted of a crime of moral turpitude or any crime relating adversely to the activity regulated by the Board. For the purpose of this subsection, a plea of guilty, non vult, nolo contendere or any other such disposition of alleged criminal

activity shall be deemed a conviction." A criminal conviction is conclusive evidence of guilt in a disciplinary proceeding, and the Board ordinarily does not look beyond that judgment; the underlying facts of the conviction are relevant, however, to determination of the appropriate discipline to be imposed. See Matter of Gipson, 103 N.J. 75 (1986).

The Board conducted an investigative inquiry on February 11, 1987 pursuant to N.J.S.A. 45:1-18, during which Dr. Hassman appeared, accompanied by his counsel, Lewis Katz, Esq. Dr. Hassman presented to the Board his understanding of the background of this matter, noting the enormous emotional stress he found himself under when, having undertaken to continue his regular visits and attentions to "Mom" - and to his father-in-law, "Pop", he was compelled to witness the daily ravages of the disease and the attendant suffering inflicted, unintentionally, by those attempting to provide nursing care to her. He suffered not only his own distress, but that of his wife and his father-in-law as well. Mrs. Davis' condition worsened each day during April, and Joseph Hassman observed her suffering from the disease as well the absence of gag reflex and inability to swallow, the swollen and protruding tongue, the difficulties with the IV machine and the swollen arms from futile efforts to find a vein. He described his anguish, and that of the family members dearest to him, as overwhelming. Although he acknowledges realizing that Mrs. Davis would likely die as a natural consequence of her illness within approximately a week - if she remained on the IV which was constantly being pulled out and reinserted in destroyed veins - he states that the pressures on him, his wife and father-

in-law had become overwhelming. Overwrought, he went out to his car after the IV incident on April 9 and withdrew, from the physician's bag which he always carried in the trunk, two syringes, a 3 cc vial of Demerol and a vial of Vistaril which he placed in his pocket. He returned to Mrs. Davis' room and, when the family was ready to conclude the visit at 4:30 p.m., he lagged behind on a pretense, loaded the syringes with each drug, and injected his mother-in-law with the intention of relieving her, permanently, of her misery - and his. Dr. Hassman states that he knows what he did was wrong, but felt overcome by the intensity of his need to help the one he loved and to free her from suffering.

We note that physicians are usually protected from such temptations by the self-generated social and professional distance which is developed by health care workers as a matter of protection against emotional onslaught, and Dr. Hassman insists that although he cares for many seriously ill patients in similar situations, he has not previously experienced a loss of personal control such as happened in this matter, due to his identification with and sympathy for his mother-in-law. Dr. Hassman has described the support provided by his patients since this matter, suggesting that they understand the unusual circumstances here and wish him to continue to provide medical care to them.

The Board has considered the act performed and its background, the criminal conviction, and the Board's responsibilities in regulating the practice of medicine in this State. We have considered the concept of "moral turpitude" and its usual

definition as an "act of baseness, vileness, or depravity in the private and social duties which a man owes to his fellow men, to society in general, contrary to the accepted and customary rule of right and duty between man and man," as discussed in State Board of Medical Examiners v. Weiner, 68 N.J. Super. 468 (App. Div. 1961), affirmed in pertinent part at 41 N.J. 56 (1963). We also heed the Court's caution on the "elasticity of the phrase and its necessarily adaptive character, reflective at all times of the common moral sense prevailing throughout the community." *Id.* at 483, 484. The Court reminded that a conviction of manslaughter requires no more than the specific intent to do the act resulting in the death, rather than intent to do a harm. *Id.*, at 486.

Bearing all this in mind, we cannot find moral turpitude in Dr. Hassman's conduct; while it was clearly intended to result in Mrs. Davis' death, there can be no question but that he was motivated entirely by his love for her, his grief in observing her daily suffering, and his awareness that it was within his power to relieve her of that suffering. We must, however, conclude that Dr. Hassman's conviction is for an offense which relates adversely to the activity regulated by the Board.

Dr. Hassman's action differs significantly from the conduct which the New Jersey Supreme Court has ruled is permissible: the informed exercise of a patient's constitutional right to privacy by ordering the withholding or withdrawal of medical treatment, even where death shall occur sooner. See Matter of Quinlan, 70 N.J. 10, at 51 to 53, fn 9. The Court held that such conduct would not be homicide nor would it be the aiding of suicide, but

rather the individual would be expiring from natural causes. The physician may assist the patient in effectuating that decision.

"The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime." *Id.* at 52.

See also Matter of Conroy, 98 N.J.321 (1985) at 350 in this regard.

We address this matter at some length because of its importance and because of the recurring nature of the problem which all physicians must face, and which here was faced by Dr. Hassman in a way which resulted in criminal conviction. The Conroy court recognized the State's interest in safeguarding the integrity of the medical profession by not participating in acts likely to lead to the death of an individual, but the court found that this interest, like the interest in preventing suicide, is not actually involved when permitting competent patients to refuse life-sustaining medical treatment, since "Medical ethics do not require medical intervention in disease at all costs." *Id.* at 351,352.

The Conroy court (p.352) reiterated its reminder in the Quinlan case that modern-day

"physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable."

The Court now expressly encourages consideration of prior

statements made by individuals concerning distaste for artificial prolongation of the lives of persons who are terminally ill. The Court also gives active encouragement to advance planning for such contingencies by calling attention to the preparation of "living wills" and the filing of a durable power of attorney.

It does not appear, however, that Mrs. Davis had prepared either a living will or a durable power of attorney. At the present inquiry, Dr. Hassman's attorney represented, on behalf of his client, that at some time in the past Mrs. Davis had discussed with Dr. Hassman the sad plight of a friend being kept alive on artificial life supports. However, Dr. Hassman had not presented this as a motivation for his act, and clearly his affirmative act went well beyond implementation of an individual's personal declaration to decline medical treatment.

At present, a physician can protect the personal interests of his/her patient or loved one only by measures consonant with current law. These include encouragement to plan ahead by discussing one's wishes with family and physician - and better yet, by drawing a Living Will. Then, when the time comes and we can no longer express our preferences to those who hold the power to prolong the agony or the humiliation of existence, our wishes have been made known, and we can hope to trust that our physician will honor those preferences. For those who failed to announce their choices in time, a physician or family member or other loving friend must apply to the Courts for a declaration of incompetency, and for appointment as a special guardian with authority to apply the so-called limited objective or, if necessary, the pure objective test to determine whether medical

treatment should be withheld or withdrawn. The guardian can make such a decision only after consideration of evidence concerning the medical condition as furnished by the attending physician and nurses. That medical evidence must address the patient's condition, treatment, and prognosis, including

"evidence about the patient's present level of physical, sensory, emotional and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options." Conroy, supra, at 363-364.

According to the Conroy court, in a nursing home context (such as in the case of Mrs. Davis) that medical evidence must show an elderly, incompetent person with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less.* The Ombudsman for the Institutionalized Elderly must be notified. The Court then suggests what some may regard as a potentially costly and unworkable addition to that process: the appointment by the Ombudsman of two other physicians unaffiliated with the nursing home and with the attending physician, who must, if further action is to be taken, confirm the patient's medical condition and prognosis. (Note in this context the impropriety of the reported rejection by the head nurse of a consultant physician

* We note in this regard the powerful dissent of Justice Handler, finding these parameters far too stringent. The policy statement issued by this Board in July 1986 similarly called attention to the need for physicians to take a more realistic approach to their patients to "insure the greatest degree of physical and spiritual tranquility for those terminally or intolerably afflicted."

to whom the family was referred, because he was "not on the staff".) Finally,

"Provided that the two physicians supply the necessary medical foundation, the guardian, with the concurrence of the attending physician [who may be replaced by the guardian with another physician having different views], may withhold or withdraw life-sustaining medical treatment if he believes in good faith, based on the medical evidence and any evidence of the patient's wishes, that it is clear that the subjective, limited-objective, or pure-objective test is satisfied." Conroy, supra, at 384.

The Court requires that the Ombudsman agree as must the immediate family - unless the decision has been based upon the patient's "carefully considered position, especially if written," regarding "the details about the level of impaired functioning and the forms of medical treatment that one would find tolerable..."

In summary, we must conclude that however well-meaning were Dr. Hassman's intentions for his mother-in-law's condition, it is at present impermissible to cause a death for the purpose of euthanasia by affirmative act, even where the individual would have qualified under Conroy standards for determination by a special guardian to withhold or withdraw medical treatment. Dr. Hassman's act was particularly facilitated by his privileges as a physician which permitted him access to drugs and application of his knowledge in their use. We must also take note of the fact that the administration of the drug was surreptitious and was only discovered by the astute observations of the head nurse, even while we recognize that the deception was not for its own sake or to further his own interests, but because once Dr. Hassman had determined upon a course of action, secrecy was the only condition in which it could be carried out. Physicians must not function in secret lest patients and the public be fearful of

trusting them. Decisions affecting the health, safety and welfare of the public - even in the circumstances shown here and even if Mrs. Davis had requested Dr. Hassman to administer the lethal dose - must be made in a professional manner open to the scrutiny and professional evaluation of their peers and of this Board. The risk of abuses of judgment, whether willful or merely negligent, is minimized when major decisions are discussed openly among the interested parties, applying our best and most conscientious efforts. This is especially so when we must deal with problems entailing highly emotional factors and whose resolution may well be irrevocable.

The Board believes that a more fundamental societal assessment is both necessary and appropriate as to when a physician may, in the words of Francis Bacon, "mitigate pain and dolours...when it may serve to make a fair and easy passage."* However, until such time as the law authorizes such affirmative acts by a physician as taken in this case, we must find that it is conduct which adversely relates to the practice of the profession, thus warranting disciplinary action.

* "...I esteem it the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage..." Francis Bacon, The Second Book of Francis Bacon of the Proficiency and Advancement of Learning Divine and Human, published in 1605. The essay may be found in Selected Writings of Francis Bacon, Dick, ed., The Modern Library, Random House, Inc. 1955, at pp 277-278.

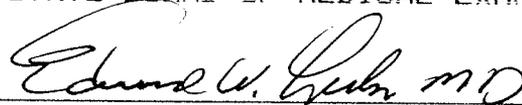
While not all of the Board members were of the same mind in determining appropriate disposition of this case, taking into account the entire background of this matter,

IT IS, on this 8th day of April 1987

ORDERED that the license to practice medicine and surgery heretofore issued to Joseph M. Hassman, D.O. shall be revoked and he shall comply with the Guidelines for Disciplined Licensees which are attached hereto and incorporated in this Order. In anticipation of this Order, Dr. Hassman has made transfer arrangements for his patients and has closed his practice as of April 1, 1987. This Order shall therefore be effective retroactively as of April 1, 1987. He may apply for relicensure no earlier than six months from the effective date of the Order.

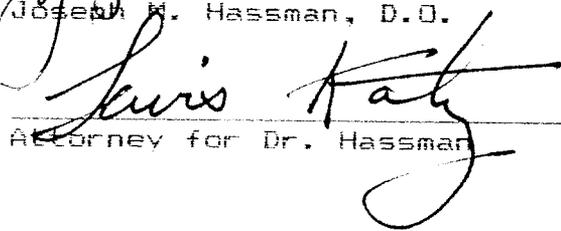
STATE BOARD OF MEDICAL EXAMINERS

BY:


Edward W. Luka, M.D.
President

I consent to the terms and entry of the within Order.


Joseph M. Hassman, D.O.


Attorney for Dr. Hassman

DIRECTIVE REGARDING FUTURE ACTIVITIES
OF MEDICAL BOARD LICENSEE WHO HAS BEEN DISCIPLINED

A practitioner whose license is suspended or revoked or whose surrender of license with or without prejudice has been accepted by the Board shall conduct him/herself as follows.

- 1) Promptly deliver to the Board the original license and current biennial registration and, if authorized to prescribe drugs, the current State and Federal Controlled Dangerous Substances registrations.
- 2) Desist and refrain from the practice of the licensed profession in any form either as principal or employee of another.
- 3) Inform each patient at the time of any inquiry of the suspended or revoked or retired status of the licensee. When a new professional is selected by a patient, the disciplined practitioner shall promptly make available the original or a complete copy of the existing medical record to the new professional, or to the patient if no new professional is selected. Such delivery of record does not waive any right of the disciplined practitioner to claim compensation earned for prior services lawfully rendered.
- 4) Not occupy, share or use office space in which another licensee practices the profession.
- 5) Desist and refrain from furnishing professional services, giving an opinion as to the professional practice or its application, or any advice with relation thereto; and from holding him/herself out to the public as being entitled to practice the profession or in any way assuming to be a practicing professional or assuming, using or advertising in relation thereto in any other language or in such a manner as to convey to the public the impression that such person is a legal practitioner or authorized to practice the licensed profession. This prohibition includes refraining during the period of suspension or revocation from placement of any advertisement or professional listing in any advertising medium suggesting eligibility for practice or good standing, such as listing in a professional directory of any type or a telephone directory or radio or television advertisement.
- 6) Not use any sign or advertise that such person, either alone or with any other person has, owns, conducts or maintains a professional office or office of any kind for the practice of the profession or that such person is entitled to practice, and such person shall promptly remove any sign suggesting ability of the disciplined practitioner to practice the profession.
- 7) Cease to use any stationery whereon such person's name appears as a professional in practice. If the practitioner was formerly authorized to issue written prescriptions for medication or treatment, such prescription pads shall be destroyed if the license was revoked. If the license was suspended, the prescriptions shall be destroyed or shall be stored in a secure location to prevent theft or any use whatsoever until issuance of a Board Order authorizing use by the practitioner. Similarly, medications possessed for office use shall be lawfully disposed of, transferred or safeguarded.

8) The disciplined licensee shall require that for a six-month period following the start of a suspension or revocation of license, a message be delivered to those telephoning the former office premises advising former patients where they may obtain their records. The message may inform callers that the practice is now being conducted by (another) named licensee, and the new telephone number of that licensee may be announced. The same information shall be disseminated by means of a notice to be published at least once per month for the same six month period in a newspaper of general circulation in the geographic vicinity in which the professional practice was conducted.

9) Not share in any fee for professional services performed by any other professional following the suspension, revocation or surrender of license, but the practitioner may be compensated for the reasonable value of the services lawfully rendered and disbursements incurred on the patient's behalf prior to the effective date of the suspension, revocation or surrender.

10) Use of the professional premises. The disciplined licensee may allow another licensee to use the office premises formerly occupied by the disciplined licensee on the following conditions only:

(a) The new licensee shall conduct the practice in every respect as his/her own practice including billings, claim forms, insurance provider numbers, telephone numbers, etc.

(b) The disciplined licensee may accept no portion of the fees for professional services rendered by the new licensee, whether by percentage of revenue, per capita patient, or by any other device or design, however denominated. The disciplined licensee may, however, contract for or accept payment from the new licensee for rent (not exceeding fair market value) of the premises and/or equipment.

(c) No use of name of disciplined licensee or personally owned office name or tax- or provider identification number.

1. Where the disciplined licensee was using an individual IRS number or where the licensee was the sole member of an incorporated professional association or a corporation, the disciplined licensee may contract to rent the office premises to a new practitioner. The new practitioner must use his/her own name and own provider number on all bills and insurance claim forms. Neither the name nor the number of the disciplined licensee may be used. When the license of a sole practitioner has been revoked, a trade name must be cancelled and a professional service corporation must be dissolved.

2. Where the disciplined licensee is a member of a professional group which uses a group-type name such as the ABC Medical Group. The disciplined licensee must arrange to have his/her name deleted, covered up or otherwise obliterated on all office signs, advertisements published by the group after the effective date of the Board disciplinary Order and on all printed billings and stationery. The other group members may continue to function under the incorporated or trade name, minus the name of the disciplined licensee, and may continue to use its corporate or professional identification number.

- 11) Report promptly to the Board compliance with each, directive requiring moneys to be reimbursed to patients or to other persons or third party payors or to any court, and regarding supervisory reports or other special conditions of the Order.
- 12) A practitioner whose license is surrendered, revoked or actively suspended for one year or more shall conduct him/herself as follows:
 - 1) Promptly require the publishers of any professional directory and any other professional list in which such licensee's name is known by the disciplined licensee to appear, to remove any listing indicating that the practitioner is a licensee of the New Jersey State Board of Medical Examiners in good standing.
 - 2) Promptly require any and all telephone companies to remove the practitioner's listing in any telephone directory indicating that such practitioner is a practicing professional.
- 13) A practitioner whose practice privileges are affected by a Board disciplinary Order shall, within 30 days after the effective date of the Board Order, file with the Secretary of the Board a detailed affidavit specifying by correlatively lettered and numbered paragraphs how such person has fully complied with this directive. The affidavit shall also set forth the residence or other address and telephone number to which communications may be directed to such person. Any change in the residence address or telephone number shall be promptly reported to the Secretary.