

FILED

APRIL 8, 2009

*William C. Kelly*

STATE OF NEW JERSEY  
DEPARTMENT OF LAW & PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
STATE BOARD OF MEDICAL EXAMINERS

|                                  |   |                       |
|----------------------------------|---|-----------------------|
| IN THE MATTER OF THE SUSPENSION  | : | Administrative Action |
| OR REVOCATION OF THE LICENSE OF: | : |                       |
|                                  | : | ORDER CONTINUING      |
| PARVEZ DARA, M.D.                | : | TEMPORARY SUSPENSION  |
| License MA 33292                 | : | OF LICENSE            |
|                                  | : |                       |
| TO PRACTICE MEDICINE AND SURGERY | : |                       |
| IN THE STATE OF NEW JERSEY       | : |                       |
|                                  | : |                       |

This matter was initially heard before a Committee of the State Board of Medical Examiners on April 3, 2009 before Paul Mendelowitz, M.D., Board President, and Joseph Reichman, M.D. The Committee entered an Order temporarily suspending the license of respondent Parvez Dara, M.D., to practice medicine and surgery in the State of New Jersey pending the completion of plenary proceedings in this matter (see Order of Temporary Suspension of license, filed April 7, 2009, effective upon oral announcement of the committee's decision on April 3, 2009, appended to this order and adopted here in its entirety). The Order of the Committee, together with the record from the hearing, was presented to the full Board of Medical Examiners on April 8, 2009, for review, so as to afford the full Board an opportunity to determine whether to ratify, reject or modify the action taken by the Committee (see Order of Temporary Suspension, p. 27). On that date, the Board heard arguments of counsel.

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The full Board has reviewed the Order of the Committee and the record below, and considered arguments of counsel. The Board unanimously votes to ratify and adopt, in its entirety, the Order of the Committee. The Board finds the reasoning of the Committee, outlined at length in the Committee's order, convincingly supports the Committee's conclusion, and now this Board's conclusion, that a palpable demonstration has been made that respondent's continued practice would present clear and imminent danger to public health, safety and welfare, and the concomitant conclusion that no measure short of the temporary suspension of respondent's license would be sufficient or appropriate in this case. The license of respondent Parvez Dara, M.D., shall therefore continue to be temporarily suspended, pending the completion of plenary proceedings in this matter, for the reasons set forth at length in the Order of the Committee. Having found that his continued practice represents a clear and imminent danger to the public health, safety, and welfare, the Board denies respondent's motion for a stay of the terms and effect of this order.

**WHEREFORE, IT IS ON THIS 8th DAY OF April, 2009**

**ORDERED:**

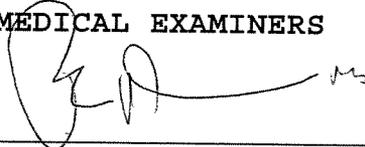
1. The Board adopts, in its entirety, the Order of its Committee filed on April 7, 2009.

2. The license of respondent Parvez Dara, M.D. shall continue to be temporarily suspended, pending the completion of plenary proceedings in this matter or further Order of the Board.

3. Respondent's motion to stay the effect of this order is denied.

NEW JERSEY STATE BOARD OF  
OF MEDICAL EXAMINERS

By: \_\_\_\_\_

  
Paul Mendelowitz, M.D.,  
Board President

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**FILED**

April 7, 2009

**NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY  
DEPARTMENT OF LAW AND PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION  
OR REVOCATION OF THE LICENSE OF

**PARVEZ DARA, M.D.**  
LICENSE NO. MA 33292

Administrative Action

ORDER OF TEMPORARY  
SUSPENSION

TO PRACTICE MEDICINE AND SURGERY  
IN THE STATE OF NEW JERSEY

On March 27, 2009, Anne Milgram, Attorney General of the State of New Jersey, filed with the New Jersey State Board of Medical Examiners (Board) an Order to Show Cause and Verified Complaint seeking the temporary suspension of the license of Parvez Dara, M.D. (Dr. Dara or respondent). The emergent action was in response to allegations that five of respondent's patients had contracted hepatitis B, most likely from multiple and significant breaches of infection control standards in his office. Those breaches were rampant in an office where immuno-suppressed patients were receiving invasive procedures involving injections, infusions of chemotherapy, and blood tests. These conditions were alleged to exist despite notice to Dr. Dara of various lapses dating back to 2002 in the context of violations issued by the Occupational Safety and Health Administration (OSHA), including a citation for a willful violation of OSHA standards in 2008. The Attorney General

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alleged that respondent's judgment was responsible for permitting the violations to continue unabated through March 2009. She argues current sanitary office conditions achieved after extraordinary efforts on behalf of respondent and his team of remediation experts have not altered the fundamental flaws that prompt the relief sought.

The exigent nature of the application required that the matter not wait for the Board's regular monthly meeting. The Order to Show Cause scheduled the hearing before a committee of the Board for Friday, April 3, 2009 at 9:00 a.m., with the committee's determination to be considered by the full Board at its meeting on April 8, 2009.

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In support of her application, the Attorney General, by Siobhan Krier, Deputy Attorney General, submitted the certifications of Barbara Montana, M.D., M.P.H., F.A.C.P., Medical Director, Division of Epidemiology, Environmental and Occupational Health, Department of Health and Senior Services (DHSS), Karen Scott, Registered Environmental Health Inspector, Regulated Medical Waste, and Paula Dixon-Roderick, Acting Area Director, Department of Labor, OSHA, each with exhibits attached.

On April 1, 2009 Dr. Dara, through his counsel, Kern Augustine, Conroy & Schoppman, by Robert Conroy, Esq., submitted his Answer denying the allegations of the Verified Complaint and asserting six separate defenses. Attached to the Answer were

certifications from: Matthew Steger, Esq., an attorney with the Kern Augustine firm (with attachments); Peter Till, Esq., co-counsel for respondent; and from Tina Lamberski, R.N. CIC (with attachments). As scheduled, a committee of the Board (Paul Mendelowitz, M.D., Board president, and Joseph Reichman, M.D.) heard the matter on April 3, 2009.

Respondent, who was initially licensed in this State in 1980, is Board certified in both oncology and internal medicine. He limits his practice to hematology and oncology, maintaining offices at 214 Commons Way, Toms River, New Jersey and 70 Lackey Road, Whiting, New Jersey. He has privileges at Community Medical Center and Health South Rehabilitation. He consults for Deborah Heart and Lung Hospital. Dr. Dara's patients receive bone marrow and chemotherapy treatment and injections at his Toms River office. Blood samples for testing are drawn at both offices.

As detailed in Dr. Montana's testimony and in the letter to Dr. Dara from Dr. Montana (P-3 in evidence, Montana Cert., Attachment A, p. 170), the investigation leading to the filing of this action began on February 24, 2009 when an employee of a physician, acting in accord with DHSS rules, reported two cases of acute hepatitis B infection in patients who had received treatment in Dr. Dara's office. That report was made to Patricia High, Epidemiologist, MHS, CHES, with the Ocean County Health Department (OCHD). Ms. High, consistent with State protocols, contacted the

patients to obtain "pertinent clinical and epidemiological data." She also contacted Christine Armenti, RN, BSN, MS, at the DHSS Vaccine and Preventable Disease Program to discuss the reported cases of acute hepatitis B infection. Ms. Armenti provided the information to Dr. Monatana.

The following day, February 25, 2009, OCHD and DHSS, reviewing the New Jersey Communicable Disease Reporting and Surveillance System (CDRSS), for the period January 1, 2008 to February 25, 2009, identified two additional cases of hepatitis B associated with Dr. Dara's office. Based on those four cases, OCHD and DHSS determined there was a potential ongoing risk to public health and an association with that office.

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On March 3, 2009, a Public Health Investigation Team (PHIT) comprised of OCHD, DHSS, and investigators from the Board, conducted an on-site inspection at the Toms River office. Dr. Dara was not present (he was on vacation) but his staff permitted the inspection to go forward. Peter Till, Esq., was informed and was present for part of the time. Patients present were receiving invasive procedures: injections and phlebotomy services. Because respondent was away, the last chemotherapy administration had been on Thursday, February 26, 2009.

During the March 3, 2009 inspection, the PHIT took photographs of the layout of and conditions existing in the office, including photographs depicting substandard infection control

practices(P-6 in evidence), interviewed staff members who relayed a lack of knowledge as to office policies and procedures for prevention of blood borne pathogen transmission, and reviewed patient charts. In matching patient files to the CDRSS, a fifth case of hepatitis B was identified in a patient associated with Dr. Dara's office. Based on all the above and in consultation with the Centers for Disease Control and Prevention (CDC), DHSS and OCHD determined that in the interest of public safety, patient care at that location should cease.

The PHIT conducted a second site visit on March 10, 2009, at which time Dr. Dara and other members of his clinical staff were interviewed. On March 11, 2009, the team inspected Dr. Dara's Whiting office. Dr. Dara and his staff were cooperative throughout these inspections.

DHSS and OCHD notified Dr. Dara of its findings in a letter from Dr. Montana on March 16, 2009. Dr. Montana identified:

numerous lapses in infection control techniques that might have been responsible for the identified outbreak of hepatitis B injection associated with your practice [in] Toms River. These lapses represent a public health threat and place patients at risk for transmission of blood borne pathogens including hepatitis B, hepatitis C and HIV.

[P-3 in evid., Montana Cert., Attachment A, p. 171]

Dr. Montana laid out a comprehensive plan for remediation detailing numerous required actions, and requested Dr. Dara's continued cooperation as DHSS and OCHD continued the investigation

and arranged for testing of patients potentially exposed to blood borne pathogens.

Respondent took steps to address the deficiencies identified in Dr. Montana's correspondence. Ms. Lamberski, an infection control specialist, detailed her corrective actions and recommendations (R-3 in evidence). Based on those representations and other information available, DHSS did not prevent Dr. Dara from reopening the office for non-invasive procedures (no injections, no blood draws, no chemotherapy administration) in late March. Respondent had proposed that limited opening as the first phase of his three phase plan to fully reopen his practice.

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On March 16, 2009, DHSS and OCHD learned that the Occupational Safety and Health Administration (OSHA) Marlton office had previously received anonymous employee complaints regarding conditions at respondent's Toms River office. Those complaints prompted inspections in 2002, 2007, and 2008, which lead to multiple citations related to many breaches in infection control practices (P-5 in evidence; certification of Paula Dixon-Roderick with attachments). In light of that information, DHSS determined that the group of patients who should be tested for exposure would be expanded to include those receiving treatment from as early as 2002. As DHSS was addressing the concerns raised by its investigations, the Attorney General filed this action before the Board to address respondent's conduct.

In seeking emergent relief, the Attorney General alleged that respondent had failed to implement adequate infection control procedures resulting in a risk of harm and actual harm to patients. The Verified Complaint enumerated a litany of alleged breaches and deficiencies:

- \* failure to adequately clean environmental surfaces and supplies;

- \* failure to maintain equipment;

- \* failure to develop infection control policies and procedures and to ensure staff were adequately trained in infection control techniques;

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- \* failure to provide appropriate environmental controls and/or job assignments to eliminate the potential for blood contamination during medication preparation and administration;

- \* failure to properly handle medications and solutions, including improper handling of multi-dose vials (failure to develop policies for establishing shelf life);

- \* use of bags of intravenous solutions as a common source of medication or fluid for multiple patients;

- \* failure to label filled syringes and prepared medical solutions;

- \* failure to properly store medications resulting in potential contamination;

- \* failure to adequately supervise and ensure competency of

staff performing patient care activities, including permitting a licensed practical nurse to independently: access patients portacaths, administer chemotherapy, obtain peripheral access for medication infusion, prepare chemotherapy agents, and monitor infusion patients);

- \* failure to adhere to aseptic technique (ensure proper hand hygiene and use of gloves by staff;

- \* removal of needles and syringes from sterile packages and storage outside sterile packages prior to intended use;

- \* failure to properly use antiseptics prior to performance of invasive procedures; failure of staff to have access to appropriate personal protective equipment;

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- \* failure of staff to appropriately use and dispose of personal protective equipment);

- \* failure to update written policies and procedures;

- \* failure to standardize procedures for peripheral and portacath access, care, and flushes;

- \* failure to adhere to regulated medical waste management regulations (in Toms River office red sharps containers not free of material on inner and outer surfaces;

- \* failure to properly report waste class; waste tracking forms not available; in the Whiting office failure to have waste tracking forms available for review.

On April 3, 2009, the committee convened. Respondent

moved to dismiss the case asserting that the complaint lacked verification as the deputy attorney general signing the certification did not have first hand knowledge of the facts alleged. The committee denied the motion, noting that N.J.S.A. 45:1-22 requires only that the application be verified, and the requirement was satisfied. The certifications of Dr. Montana, Ms. Scott, and Ms. Dixon-Roderick addressed the factual basis for the allegations in the complaint, and Dr. Montana was appearing as a witness at the hearing.

After opening statements, the Attorney General presented Dr. Montana as the State's chief and only witness. Dr. Montana is employed by DHSS as Medical Director of the Clinical Disease Service, where she assists with and oversees the investigation of outbreaks of communicable diseases. She is Board certified in both internal medicine and infectious disease, holds a masters degree in Public Health, has a private clinical practice and teaching positions. She was qualified as an expert in epidemiology and testified as both a fact witness and an expert. (P-7 in evidence, Montana curriculum vitae).

Dr. Montana presented a thorough and competent review of the circumstances that started the investigation: the OCHD epidemiologist's report of two patients, without traditional risk factors (e.g., intravenous drug use; sex with multiple partners) presenting with acute hepatitis B. These patients had only a

health care treatment link as a risk for the disease. When the CDRSS report was reviewed, two additional cases in older adults - again not typical for acute hepatitis B - were identified. All four patients had received care at Dr. Dara's office. All four had received invasive procedures at the site (infusion or injection) and one patient had not received care anywhere else during the six month incubation period. Using epidemiological data, other locations including the hospital and other physician's offices were ruled out as the likely source of the hepatitis B infection. A fifth case epidemiologically associated with respondent's office was identified upon review of patient files during the March 3, 2009 inspection of respondent's office.

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Having been present at the inspections of respondent's offices and having attended and conducted interviews with his staff, Dr. Montana testified to her first hand observations of the extremely deficient infection control conditions present in Dr. Dara's office on March 3, 2009. As she reviewed the color photographs taken during that inspection, Dr. Montana identified the multiple and egregious deficiencies in, and breaches of, infection control practices evident in the pictures. Starting with the chemo room, Dr. Montana commented on the close proximity of the chairs to each other. As droplets may have a transmission distance of three to six feet, she noted the better practice is to keep chairs about three feet apart. (Indeed, respondent's own consultant

recommended removal of two to three chairs as a corrective action). When discussing the chemical hood in which chemotherapy drugs are mixed, Dr. Montana testified that keeping materials clean and sanitary was essential for the health of patients.

In stark contrast to that standard, the hood in Dr. Dara's office contained a basket, bandages, an uncovered digital oral thermometer, a box of probe covers blocking the vent for the hood, medication vial, a syringe filled with medication, and additional open, filled, unlabeled syringes. As the last day chemotherapy was administered in the office was February 26, 2009, these items had presumably been in the chemical hood since that time. Dr. Montana stated there is a "substantial risk of contamination" if any of these items stored in this improper manner were used on a patient.

Critically, Dr. Montana testified that in the chemo room, on the mayo stand, a blue basket containing non-sterile gauze and vacutainers, had an obvious blood stain next to the sterile gauze. Dr. Montana commented that this was "very significant" because it is adjacent to open wounds creating the potential for transmission of blood borne pathogens, including hepatitis B.

In addressing issues related to single and multi-use vials and use of saline bags for multiple patients, Dr. Montana plainly and emphatically stated that this should not be done. "Blood borne pathogen transmission is really a never event. It's

because of inappropriate handling." (Montana, T 52, emphasis added) She reviewed the manner in which these products as used in respondent's office could become contaminated, both with bacteria and blood borne pathogens.

She noted that a single patient use chemotherapy vial containing powder, which is to be reconstituted with sterile water, is not appropriate for multi-patient use as the sterile water does not contain preservatives, thus creating the potential for contamination because of risk of bacteria growth. An open vial, with a handwritten date of 2/09, was found half-full in the refrigerator and another vial with a handwritten date retrieved from a medical waste container supported her conclusion that single use containers were being used for more than one person, a practice acknowledged by staff in interviews. Dr. Montana also observed bags of saline without stoppers and testified that staff reported that they used one bag of saline for the day, to prepare medications and draw flushes for multiple patient use. She noted that each time the bag is entered, it is susceptible to contamination from a bacterial point of view. If contaminated with a pathogen and used for multiple patients, all of those patients would be exposed to the pathogen. She testified that staff had no knowledge of a consistent policy for retaining medications after they were open.

Dr. Montana's observations and interviews with staff, and

in particular, her assessment of staff practices during a "walk through" (with no patient present, this was simulated encounter in which staff members detailed all interactions and procedures), yielded more evidence of multiple infection control breaches. Staff members used communal pens while wearing contaminated gloves. All but one staff member used the sink into which the Cell Dyn machine tube emptied as a primary hand washing sink. The sink in the phlebotomy room, used by another staff member, was surrounded by papers and blood drawing equipment. Syringes were opened "for the week" - a gross deviation - and placed in a communal basket adjacent to the Cell Dyn machine and near a pen that was used by staff while wearing contaminated gloves. Because the top is removed from the vial of blood to run the sample with this practice, Dr. Montana stated there was a "high chance" of contamination.

The risk of contamination was also glaringly present in the chemo room. Dr. Montana identified photographs showing blood smears, blood droplets, debris, a catheter cap, pretzel pieces, and other materials on the floor. Calling hepatitis B "a hardy virus" that can live on surfaces for about seven days, Dr. Montana again expressed her concern for the potential for transmission of blood borne pathogens particularly in immuno-suppressed patients.

Dr. Montana concluded her direct testimony by identifying numerous and significant breaches in practices, deviations from the

CDC's guidelines for gloving, for hand washing, use of multi-dose vials, use of single dose vials and saline bags for multiple patients, and offered her expert opinion that Dr. Dara did not use appropriate precautions or prevent environmental contamination.

When challenged on cross examination, Dr. Montana firmly and convincingly defended the conclusion of the epidemiological team that the highly likely source of the infection was Dr. Dara's office. She again detailed the methodology employed: using a specific (and long) six month incubation period and examining the procedures performed and the location(s) where they were performed, the team was able to identify an association with respondent's office and exclude an association at other sites where patient's

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may have been seen. Dr. Montana testified that within the incubation period, procedures associated with transmission were only performed at Dr. Dara's office. While the evaluation of information continues, Dr. Montana stated: "Given the information that we had, including the patients and what we observed in the office practice, we believed that it was highly - highly likely that there was a connection in that there was a reason to act imminently before we completed all the information to do that final statistical analysis." (Montana testimony; T 119).

Dr. Montana acknowledged that at this time, DHSS does not know if it is a single or multiple point source within respondent's office; does not know who introduced it; does not yet have

information on genetic testing of the virus. Yet, she testified repeatedly and emphatically that evidence of environmental contamination and poor practice at this office can lead to this outbreak. Based on clinical observations, patient records, and all other information she detailed, Dr. Montana said it was prudent for DHSS to act in the interest of public health to stop treatment at respondent's office locations.

Referring to the significant relief the Attorney General was seeking in the application, Dr. Dara's counsel asked: "Doctor, is it good and accepted epidemiological practice to take action without having statistical testing done on the data?" Dr. Montana replied:

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I think it depends on the purpose of why you are doing the epidemiological test, and in this case, the final epidemiological results are not as important as patient safety, and given the information that we had at hand with the clinical information that we had and based on our observations of the site and of the practices at that site, it was prudent as the Department of Health to act to cease performing procedures that would put patients at risk, so this isn't a theoretical epidemiologic study for a peer review journal; this is -has an impact on actual patient health, and in those situations, we don't wait for the ultimate epidemiological analysis to get final statistics; we behave in a way to protect patient safety as the Department of Health. [Montana T 158]

At the conclusion of Dr. Montana's testimony the Committee confirmed the exhibits that had been or were being introduced into evidence:

P-1 Copies of patient records from Dr. Dara's office for C.S.P., M.H., C.C., J.W., and R.G.

- P-2 March 18, 2009 memorandum to William Roeder, Executive Director, Board of Medical Examiners, from Barbara Montana, M.D., Medical Director, Division of Epidemiology, Environmental and Occupational Health (redacted)
- P-2a Same as P-2 (unredacted)
- P-3 Certification of Barbara Montana, M.D., with attachments
- P-4 Certification of Karen Scott, Registered Environmental Health Inspector, Regulated Medical Waste, DHSS, with attachments
- P-5 Certification of Paula Dixon-Roderick, Acting Area Director, United States Department of Labor, Occupational Safety and Health Administration, with attachments
- P-6 Color photographs of Dr. Dara's Toms River office; March 3, 2009
- P-7 Curriculum Vitae, Barbara Montana, M.D.
- P-8 Order to Show Cause, Notice of Hearing and Notice to File Answer; Verified Complaint; Certification of Siobhan Krier; Certifications of Barbara Montana, M.D., with attachments; Karen Scott, with attachments; Paula Dixon-Roderick, with attachments.

The State then rested.

In response to the State's case, respondent's counsel represented that Mary Blanks, M.D., who was out of the country, was available by telephone should the Committee "wish to ask her any questions with regards to any of the issues that may have come up . . . ." He then moved R-1, certification of Tina Lamberski, R.N., with attachments; R-2, certification of Peter Till, Esq.; and R-3, certification of Matthew Steger, Esq., with attachments, into evidence. Although he had subpoenaed two individuals from the Ocean County Health Department, respondent did not call them as witnesses. Counsel then advised: "At this time based on Dr.

Montana's testimony we don't think there's a need for any further testimony. We rest."

The committee members advised counsel that they would like to hear from Dr. Dara. Counsel did not object to the committee asking Dr. Dara to testify, but asked that any examination by the Attorney General be limited to lines of questions raised by the Board members present. After a brief Executive Session, the committee called Dr. Dara noting that he was appearing voluntarily and that his testimony was not being compelled by the Board.

Dr. Dara testified that he is in the Toms River office three days a week and sees between 45 and 60 patients a day. When asked about indications that the number of patients seen in his office each day was 60 to 80, respondent indicated that some patients who are having blood work done are not seen by him. He denied that injections are given when he is not in the office. He stated chemotherapy is only administered when he is in the office, but noted that he does leave the office after starting therapy for periods of time when patients are receiving long infusions (nurses are present). Dr. Dara briefly described his interactions with patients and stated that he trained the nurses who mix the chemotherapy drugs. He asserted that he explained how toxic the drugs are, and that he oversees treatment "to make sure nothing is compromised" (Dara T18). Respondent testified that during a two

and a half week period when a registered nurse was not on staff, he personally prepared and administered the drugs, including accessing the patients' ports. He stated the LPN who assisted him did not administer chemotherapy or train an RN to do so. He stated she only told the RN how to order the drugs.

Dr. Dara's testimony demonstrated to the committee that he has no clear understanding of the relevance of his history of repeated and at times unaddressed OSHA violations, his lack of oversight for his practice and his staff, or his failure to establish and maintain appropriate sanitary and infection control practices in his office. He had no insight as to how his office, ~~so rife with infection control breaches, could possibly be the~~ cause of a hepatitis B outbreak. Further, his testimony as to the practices in his office was in stark contrast to the statements and demonstrations of his staff members. It appears he either did not know what his staff was doing or that he is simply not credible.

In response to questions regarding use of single dose vials of medication for multiple patients, respondent testified that he "cannot believe" someone would use a single dose for more than one patient and that such conduct would violate his office policy (Dara T34-35). He denied that his office staff would use saline to flush ports of the chemotherapy, and if it were done, he asserted, it would violate his office policy as multi-dose bacteria static water would be used for that purpose. When asked if he

trained his staff in these policies, respondent said "yes" (Dara T-36).

Notably, respondent was not familiar with any certification process for the chemical hood in his office; he was not asked questions regarding the materials that were in the chemical hood during the March 3, 2009 inspection.

The committee members questioned Dr. Dara on the history of OSHA violations at his office. Respondent testified that after the initial violation, he assigned the task of keeping manuals up to code to his staff. He identified three individuals to whom the task was serially delegated. After the third person, Dr. Dara said he had a "short period of time with nobody who did it for about two

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to three months." (Dara T 22) The task has now been assigned to his office manager. Dr. Dara testified that the OSHA violation "was mostly paperwork" (Dara T-40). When questioned by the deputy attorney general, respondent acknowledged that he was cited in 2002 for failing to implement an exposure control plan, and failing to offer blood borne pathogen training to employees. He asserted, however, that he obtained proper personal protection equipment after the violation.

Dr. Dara testified that given his patients are at risk from immuno-suppressive issues, he told his staff "how important it is for all of them to be clean. They have to make sure hand washing is done. I have specified to each and every one of them

the importance of this process when you take care of patients." (Dara T-23). When he learned there were several patients who had developed acute hepatitis B in the practice, he described his reaction: "I was shocked and I ... and I was absolutely dumbfounded that this could happen in my office. And so I actually went and did some research on this to see whether this is the case or not ...." (Dara T24).

Dr. Dara then offered his theory that there is a reactivation of hepatitis B in latent patients when they receive cytotoxic therapy and/or Decadron. He indicated that practitioners are generally unaware of this and that he will be pre-screening patients prior to treatment. When asked how his theory could explain the patients' profile for acute hepatitis, including Igm antibody, he argued that a mutation in the DNA could act like an active hepatitis.

When asked if he didn't think it curious that in the 29 years of giving chemotherapy he had not had a case and then suddenly he had five cases, Dr. Dara referred to the treatment two patients received including surgeries and transfusions, and questioned whether the patients were carriers, raising the possibility for him that it was reactivation rather than direct transmission. That the procedures occurred outside the incubation period for acute hepatitis was not dispositive for Dr. Dara who asserted: "... if it is latent, it is latent, and if you reactivate

it with chemotherapy - and both of them got reactivated within the quote, unquote, 45 days to 150 days of reactivation period." (Dara T28).

The Committee entertained closing arguments and went into executive session to deliberate.

After fully reviewing the record created, including the testimony of Dr. Montana and Dr. Dara, and considering the arguments of counsel, the Committee has found, as detailed below, that Dr. Dara's continued practice palpably demonstrates a clear and imminent danger to the public health safety and welfare.

The finding that Dr. Dara's continued practice constitutes a clear and imminent danger rests upon the Committee's determination that his chronic and recurrent failure to have infection control practices in place in his office over a protracted period of time, despite actual notice of deficiencies, reflects manifestly poor judgment that cannot be remedied by merely altering office practices or having a monitor present.

While respondent's history of OSHA violations does not serve as the basis for the Committee's action, it does provide a picture window into respondent's practice - and his casual if not lax control over his office and supervision of his staff. The record reveals that during a May 14, 2002, inspection, respondent was cited for eleven violations, nine designated as "serious." They included employees not wearing appropriate personal protective

equipment (gloves and eye shield) when changing bottles of reagents; exposure control plan not including schedule or method for implementation of code requirements, such as testing blood, testing exposed employee, offering HIV post-exposure prophylaxis; exposure control plan not reviewed or updated annually; work practices, controls not used to eliminate or minimize employees' occupational exposure, not ensuring employee wear gloves while inverting blood filled tubes; not providing employees with training for blood borne pathogens; not providing training in hazardous chemicals (potassium, cyanide, chemotherapy drugs); not maintaining a material safety data sheet; and failing to have a written schedule for cleaning and a chemical inventory list. (Dixon-

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Roderick cert., Citation and Notification of Penalty, Inspection Number 303396295, Issuance Date, 07/24/2002; penalty \$5,400).

On November 19, 2007, OSHA again inspected Dr. Dara's office, this time citing him for four violations, all deemed "serious." (Dixon-Roderick Certification, Citation and Notification of Penalty, Inspection Number 311379218, Issuance Date 01/08/2008, Penalty \$4,500). That Notice detailed the failure to have a site specific, written exposure control plan; failure to ensure employees with occupational exposure participate in a training program; failure to launder, clean or dispose of personal protective equipment (employees were required to launder scrubs at home, outer garments not worn over scrubs); and permitting the

storage of food and beverages in the blood analysis room and permitting coffee mugs to be washed in sink directly adjacent to where blood samples were analyzed.

A followup inspection of Dr. Dara's office on March 5, 2008, resulted in a citation for a repeat violation as the employees stored food and beverages in the refrigerator in the room where blood samples were stored and analyzed. (Certification of Dixon-Roderick; Citation and Notification of Penalty, Inspection Number 311444970, Issuance Date 03/31/2008; Penalty \$4,000). OSHA also issued a Notification of Failure to Abate Alleged Violation found on November 19, 2007, as the office had not provided a site specific written exposure control plan by the abatement date of February 1, 2008. (Dixon-Roderick Cert; Notification Issuance date 03/31/08, Penalty \$5,000).

On July 23, 2008, OSHA again inspected Dr. Dara's office. On that date, more than eight months after the November 2007 inspection and more than four months after the March 5, 2008 inspection both of which resulted in assessment of penalties for failing to have a written exposure control plan, respondent **still** did not have the plan. (Dixon-Roderick Cert., Citation and Notice of Penalty, Inspection Number 312127228, Issuance date: 11/05/08). Deeming this violation to be "willful", OSHA assessed a penalty of \$22,000 and required Dr. Dara to submit the written exposure control plan within ten calendar days.

While respondent and his co-counsel may choose to characterize these violations as "almost exclusively record keeping and documentary type violations" (R-2 in evid., Till Certification, para. 4) and may assert "that the OSHA matter is being made more of than it actually, was . . .," the committee sees these actions and Dr. Dara's failure to address them as indicative of his abdication of meaningful responsibility for his office practices. The Public Health Investigative Team's observations, as detailed by Dr. Montana in her testimony, information and demonstrations provided by staff, and as identified from the photographs in evidence (P-6), show myriad breaches of infection control and failure to abide fundamental requirements for patient and occupational safety.

That failure to take responsibility appears again in Dr. Dara's testimony before the committee. In the face of highly credible and persuasive testimony from Dr. Montana regarding the epidemiological evidence that links the five cases of hepatitis B to his office, Dr. Dara proposes that these patients are latent carriers of the virus or that they contracted the disease through other venues at other times.<sup>1</sup> As medical professionals who bring our own expertise to these proceedings, we reject his proffered explanation for the putative transmission as lacking any reasonable medical basis. But even were there no discernable link between the

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<sup>1</sup> The articles referenced in respondent's brief were not provided at the hearing, but a review of the abstracts on line demonstrates that they do not support Dr. Dara's claim.

five identified patients and Dr. Dara's office, a position the Committee rejects, the conditions at that office were so woefully deficient, so violative of basic infection control practices, that the very real threat to his immuno-suppressed patients simply cannot be overstated. The high volume of patients seen every day for invasive procedures, the staff turn-over, the failure to adequately train or supervise staff, all contribute to a chaotic and dangerous environment.

Respondent's counsel argued that just as DHSS has permitted Dr. Dara to reopen his office for non-invasive procedures, so too should the Board permit him to practice. But DHSS has a different role in ensuring the public health. That respondent may have remediated the deficiencies in his office, legion though they are (see R-1, Lamberski cert., corrective action plan submitted to DHSS), he has not demonstrated that the judgment and neglect that have brought him before the Board have been addressed in any meaningful way. Instead, he rejects the scientific, epidemiological analysis and asserts his improbable theory for five patients simultaneously presenting with a latent hepatitis B infection, and seeks to have his practice continue stating that deficiencies have been remedied and he will comply with the Board's directives.

The committee is keenly aware of the heightened standard to be employed here; that a palpable demonstration of clear and

imminent danger must be found to impose a temporary suspension of license. The committee has evaluated the evidence critically and thoroughly while remembering its paramount obligation to protect the health and well being of the public. In re Polk License Revocation, 90 N.J. 550, 565 (1982). As physicians, we thoroughly understand the issues, the evidence, and the standards involved. Id. At 567-68. Practicing medicine in this State is a privilege that is burdened with conditions, paramount among them is the ongoing requirement to practice with reasonable skill and safety, to protect your patients from harm.

Dr. Dara has failed to practice with reasonable skill and safety. ~~In a position where scores of patients each day relied on~~ his medical judgment and placed their faith in him, he violated that trust. The committee, for the reasons set forth above, has determined that Dr. Dara's continued practice palpably demonstrates a clear and imminent danger to the public health safety, and welfare, and that no action short of a temporary suspension will serve adequately to protect those interests.

THEREFORE, IT IS ON THIS 7th DAY OF APRIL, 2009,

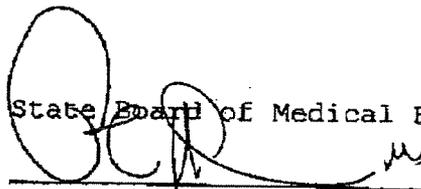
ORDERED:

1. The license of Parvez Dara, M.D., is temporarily suspended effective upon oral announcement at the April 3, 2009 hearing, pending plenary hearing on the allegations of the Verified Complaint.

2. Respondent shall comply with the ongoing efforts of the Department of Health and Senior Services to notify his patients of the need to be tested for presence of hepatitis B, hepatitis C and HIV, by supplying electronic file databases of patient names, last known addresses, dates of birth, and dates of service, for the period 2004 through March 3, 2009, and provide a status update on the preparation of the patient list for those patients treated from 2002 to 2004 (with all the above information), including available format and expected date of submission.

3. During the period of temporary suspension, respondent shall comply with the Directives for Disciplined Licensees, including the directive for patient access to medical records for ongoing care.

4. This order is subject to review and ratification by the Board at the Board's meeting on April 8, 2009. In determining whether to accept, reject or modify this order, the Board shall review the record created in this matter, including the transcripts of the April 3, 2009, hearing.

  
 State Board of Medical Examiners  
 Paul Mendelowitz, M.D.  
 President