

**FILED**

~~October 12, 2011~~

**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: :  
: Administrative Action  
PARVEZ DARA, M.D. :  
LICENSE NO. MA 33292 :  
: **FINAL DECISION AND ORDER**  
:   
TO PRACTICE MEDICINE AND SURGERY :  
IN THE STATE OF NEW JERSEY :  
:

This matter was first brought before the New Jersey State Board of Medical Examiners (Board) on March 27, 2009, by Anne Milgram, then the Attorney General of the State of New Jersey, by Siobhan Krier, Deputy Attorney General, who filed with the Board an Order to Show Cause and First Verified Complaint seeking the emergent temporary suspension of the license of Parvez Dara, M.D (hereinafter "Respondent"). Respondent, an oncologist with offices in Toms River and Whiting, New Jersey, was charged with gross and repeated acts of negligence and malpractice and with professional misconduct in violation of N.J.S.A. 45:1-21(c), (d) and (e) in regard to allegations that at the time of the First Verified Complaint five (5) of his patients had contracted the Hepatitis B virus (HBV), most likely from multiple and significant breaches of infection and blood borne pathogen control standards in his office. More specifically, Count I of the First Verified Complaint alleged that Respondent:

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- 1) failed to implement adequate infection control practices in his offices, resulting in a risk of harm, and actual harm, to his patients;
- 2) failed to maintain sanitary conditions;
- 3) failed to develop infection control policies and practices and ensure proper staff training;
- 4) failed to provide appropriate environmental controls and/or job assignments to eliminate potential for blood contamination during medication preparation and administration procedures;
- 5) failed to properly handle medications and solutions;
- 6) failed to adequately supervise and ensure competency of staff performing patient care activities resulting in breaches in infection control and placement of patients at risk for on-going transmission;
- 7) failed to adhere to aseptic technique;
- 8) failed to update written policies and procedures regularly;
- 9) failed to standardize procedures for peripheral and Portacath access, care and flushes;
- 10) failed to adhere to regulated waste management regulations in his Toms River office in that red sharps containers ... were not free of material on inner and outer surfaces, failed to properly report waste class and tracking forms were not available for review, and
- 11) failed to adhere to regulated waste management regulations in his Whiting office in that copies of tracking forms for regulated waste which was self-transported to his Toms River office was unavailable for review.

The First Verified Complaint asserted that these breaches were rampant in an office where immuno-suppressed, elderly cancer patients were receiving invasive procedures such as injections,

blood tests, chemotherapy infusions and port flushes. The Complaint alleged that Dr. Dara allowed an unsafe environment to exist by failing to implement adequate infection control procedures resulting in a risk of harm and actual harm to patients.

Count II of the First Verified Complaint alleged that the then current significant and multiple breaches in Dr. Dara's office existed despite prior notice to Respondent as he had been sanctioned by the Occupational Safety and Health Administration (OSHA), for violations of standards involving infection control. He was cited for violations in 2002, 2007 and 2008. A summary of the findings leading to sanctions imposed on Respondent by that agency is as follows:

Protective equipment was not used as necessary when hazards capable of causing injury and impairment were encountered. The specification stated that on or about May 14, 2002, an employee did not wear gloves while changing bottles of reagents;

Protective eye equipment was not required where there was a reasonable probability of injury that could be prevented by such equipment. On or about May 14, 2002, an employee did not wear eye protection while changing bottles of reagent;

The employer's Exposure Control Plan did not include the schedule and/or method of implementation for Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-Up;

The Exposure Control Plan was not reviewed and/or updated annually;

The employer did not provide sharps, with engineered sharps protection, such as safe design with a shielded, recessed or retractable needle;

The employer did not ensure that the employees used appropriate personal protective equipment when there was

occupational exposure. The specification stated that the employer did not ensure that an employee with occupational exposure, such as while inverting blood filled tubes, wore gloves;

The employer did not provide blood borne pathogen training for employees who had occupational exposure to blood or other potentially infectious materials;

Employees were not provided information and training as specified in certain CFR provisions on hazardous chemicals in their work area at the time of their initial assignment and whenever a new hazard was introduced into their work area. The specification noted such hazardous chemicals as potassium cyanide and chemotherapy drugs;

The employer did not determine or implement an appropriate written schedule for cleaning or method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present and tasks or procedures being performed in the area. The specification listed only the failure to have a written cleaning schedule; and

The written hazard communication program did not include a list of the hazardous chemicals known to be present, specifically a chemical inventory list. [Initial Decision (ID) pages 58-59].

The emergent nature of the State's 2009 application required that the matter not wait for the Board's regularly scheduled monthly meeting. Therefore a Committee of the Board consisting of two (2) plenary licensed physicians conducted a hearing on April 3, 2009 at which Respondent was represented by two (2) law firms. The Committee found that, pursuant to N.J.S.A. 45:1-22, Respondent's continued practice of medicine created a clear and imminent danger to the public and the Committee ordered that Respondent's license be immediately temporarily suspended pending completion of plenary proceedings in this matter or further order of the Board. The Board

ratified that Committee determination on April 8, 2009. After Respondent filed an answer to the First Verified Complaint denying all allegations, the matter was transferred to the Office of Administrative Law as a contested case.

On September 28, 2009 the Attorney General filed a Motion to Amend the Verified Complaint to allege that there were then twenty-nine (29) confirmed cases of HBV in Dr. Dara's patient population. Nineteen (19) were confirmed cases of acute HBV and ten (10) were confirmed cases of chronic HBV. The Amended Verified Complaint alleged that these twenty-nine (29) cases "stemmed" from or were "probably linked" to Respondent's practice. The Motion was granted, following which extensive discovery took place. Hearings were held at the Office of Administrative Law for more than twenty-five (25) days from September 8, 2010 until April 12, 2011. Administrative Law Judge (ALJ) Jeff S. Masin filed his 169 page Initial Decision (ID) on June 7, 2011. The Attorney General filed her Exceptions on July 5, 2011 and Respondent's Reply was filed July 20, 2011.

On September 14, 2011 the Board considered the Initial Decision of ALJ Masin, the Attorney General's Exceptions to that Decision and Respondent's Reply to the Exceptions to determine pursuant to N.J.A.C. 1:1-18.6(a) whether to adopt, reject or modify the ALJ's decision.<sup>1</sup> Deputy Attorneys General Siobhan Krier and Bindi

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The Board considered three pre-hearing motions. The State moved to include in the record evidence that the ALJ had previously excluded. This motion was denied as there would be no opportunity

Merchant, appeared on behalf of the Attorney General and Peter L. Korn, Esq., Richard E. Brennan, Esq., and Matthew P. Cohen, Esq. represented Respondent<sup>2</sup>.

#### **STATEMENT OF FACTS**

Respondent was initially licensed in New Jersey in 1980 and was Board Certified in oncology and internal medicine. Prior to the suspension of his license his practice was limited to hematology and oncology, including invasive procedures such as bone marrow biopsies and chemotherapy treatment, injections and blood draws with an immuno-suppressed, mostly elderly cancer stricken patient population.

The investigation leading to the State's filing of this action was detailed in the testimony of Barbara Montana, M.D. the State's chief witness (5T through 8T, 14T, 16T, 18T).<sup>3</sup> She testified as a hybrid fact/expert witness because of her role in the investigation

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for cross examination and the State did not avail itself of the opportunity for interlocutory review. The State's Motion to Reopen and Supplement the Record was also denied based on the same reasoning. Respondent's motion to dismiss the State's Exceptions for failure to comply with N.J.A.C. 1:1-18.4(b) was also denied on the basis that the Board typically grants latitude as to form requirements regarding specificity and transcript citations when considering exceptions, and has routinely considered submissions notwithstanding technical omissions.

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Respondent was represented by Robert Conroy, Esq. and Peter Till, Esq. at the time of the Emergent Temporary Suspension proceeding.

<sup>3</sup>Citations to "T" shall refer to the various transcripts of the days of hearing at the OAL, 1T representing the first day.

as the Medical Director at the New Jersey Department of Health and Senior Services (DHSS) for Communicable Disease Services, Vaccine Prevention Disease Program and the Infectious Disease Program. She is Board Certified in both Internal Medicine and Infectious Disease and holds a Masters degree in Public Health. She is currently an Adjunct Assistant Professor at UMDNJ in the Department of Epidemiology (P-9).<sup>4</sup> She was qualified as an expert in infectious disease and epidemiology. The investigation began on February 24, 2009 when an employee of the physician, in compliance with DHSS regulations, reported to the Ocean County Health Department (OCHD) two (2) cases of acute HBV infection found in Dr. Dara's patient population. Patricia High, Epidemiologist, MHS, CHES, of the OCHD contacted the patients to obtain clinical and epidemiological data and then contacted DHSS.

The next day, February 25, 2009, OCHD and DHSS identified two (2) additional cases of HBV associated with Dr. Dara's office by reviewing the New Jersey Communicable Disease Reporting and Surveillance System (CDRSS). CDRSS is the entity to which physicians are required to report known cases of HBV. The four (4) identified cases with a link to Dr. Dara's office caused the agencies to determine that there was a potential ongoing risk to public health associated with Respondent's practice.

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<sup>4</sup>Epidemiology is the study of diseases in the general population; including causes, prevention and how diseases spread.

On March 3, 2009, a Public Health Investigation Team (PHIT) comprised of OCHD, DHSS and Board investigators conducted an inspection of Respondent's Toms River office. Dr. Dara was not at the site but members of his staff and his then attorney Peter Till, Esq., were present and permitted the investigation. Patients were in the office and receiving invasive procedures such as injections and blood draws, but no chemotherapy was being administered. It was reported that the last chemotherapy administration had been on Tuesday, February 26, 2009, as respondent was away from the office.

The PHIT took photographs of the conditions existing in the office reflecting myriad substandard infection control practices (P-7),<sup>5</sup> interviewed staff members who relayed information regarding, (and demonstrated a lack of knowledge as to), the day-to-day ongoing office policies and demonstrated unsafe procedures for prevention of blood borne pathogen transmission. The PHIT also reviewed patient charts. A fifth case of HBV was identified during the chart review. A second site visit took place March 10, 2009. In consultation with the Centers for Disease Control and Prevention (CDC), DHSS and OCHD, made a determination on March 10, 2009, that in the interest of patient safety, the practice should be closed and patients who might have been at risk notified that they should be tested.

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<sup>5</sup>P-7 is the group of photographs entered into evidence as reflected in the exhibit list attached to the ID, which is incorporated herein.

On March 16, 2009 DHSS and OCHD learned that OSHA had previously sanctioned Respondent for breaches in infection control practices as early as 2002, hence the group of patients to be tested for exposure was expanded to include those receiving treatment in and after 2002. The public health investigation continued after the Attorney General filed this action and culminated with a finding that amongst Dr. Dara's patient population, there were twenty-nine (29) patients with HBV. Nineteen (19) of the patients had an acute form of the disease. Ten (10) had a chronic form. Most significantly, eleven (11) patients presented with an identical strain of the virus which was 99.9% - 100% identical (14T at pp.67, 68). Two (2) others were found to be virtually identical at 99.6%-98.9% (15T at pp. 77-85). The common thread was that all were Dr. Dara's patients.

HBV is a DNA virus which can cause either an acute or a chronic disease. Doctors are required by DHSS regulations to report any cases of HBV within twenty-four hours of diagnosis to the CDRSS. The mode of transmission of HBV is through infected blood or other bodily fluids, therefore HBV is characterized as a blood borne pathogen, similar to HIV and Hepatitis C. HBV infection is diagnosed through clinical presentation and blood testing. The virus can exist in the body without causing clinical disease and this state can be detected with blood tests. Chronic HBV infection is associated with the development of liver cancer. Chronic HBV infection can also

lead to cirrhosis, liver failure and death. In rare cases HBV can cause a fulminant hepatitis leading to liver failure and death. Traditional risk factors identified as increasing the chances of contracting HBV are exposure to infected blood, drug use, birth to an infected mother, and sex with an infected person. Generally those at increased risk includes persons with multiple sex partners and homosexual males.

Respondent's patient population is comprised primarily of elderly cancer-stricken individuals with none of the traditional risk factors for HBV. It is incumbent upon health care professionals providing care to such ill, vulnerable and susceptible patients to be responsible to assure that their offices have competent and effective infection control practices in order to provide a safe environment.

#### **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

The primary function of the Board of Medical Examiners is to protect the public health, safety and welfare by assuring medical practitioners licensed in New Jersey are properly educated, trustworthy and, most importantly, safe to practice medicine in this State. As the Board meets only once per month, it is nearly impossible for the agency to hold a trial requiring over 25 days of hearing. Therefore, although the issues were primarily scientific in nature, this matter was transmitted to the OAL to be heard by an ALJ with a final determination to be made by the Board after

consideration of the record and the recommended ID of the ALJ. The Board members who ultimately considered this matter on September 14, 2011 included eleven (11) healthcare professionals.<sup>6</sup>

As physicians and healthcare providers, we are familiar with what laymen may perceive as complex scientific issues, and understand the science at the very core of this case. The particularized medical expertise of the members make us uniquely qualified to analyze ALJ Masin's decision, including his efforts to reconcile the expert opinions in this case, and apply a causation standard in an epidemiological investigation. We believe that our expertise better equips us to evaluate the crucial importance of the genetically identical virus in eleven (11) of Dr. Dara's patients.<sup>7</sup> Therefore, after a careful review of the record, ID and applying our own medical expertise, the Board finds that ALJ Masin clearly misperceived the import of the clinical, scientific procedures, standards, theories, statistics, essential in evaluating conflicting

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<sup>6</sup>Twelve members considered the matter, ten (10) physicians, one (1) certified nurse midwife and one (1) attorney. A quorum of the Board which is required to take action consists of ten (10). Board members Stewart A. Berkowitz, M.D., Heather Howard and Sindy Paul, M.D., were recused from the matter. Sindy Paul, M.D. recused as she is a DHSS designee and DHSS participated in the investigation of this matter. Heather Howard was not present for the hearing on exceptions but is recused as she was a prior Commissioner of Health. Stewart Berkowitz, M.D. is recused as he had prior business dealings with respondent.

<sup>7</sup>Two other patients had nearly genetically identical DNA so that when considered in conjunction with the epidemiological data, they too could be considered more probable than not to have the identical virus for a total of 13 patients.

expert opinions. Yet, as a Board, with our collective medical expertise, we found the record was understandable and crystal clear.

After consideration of oral argument, written submissions and the exhibits and transcripts of the hearing at OAL, and relying on our medical expertise, we unequivocally and unanimously hereby:

**REJECT** the ALJ's Findings of Fact and Conclusions of Law found in the ID at pages 147-148 cited below in toto:

I **FIND** that the complainant has failed to demonstrate by a preponderance of the credible evidence that any of the allegedly improper procedures and techniques were more probably than not the actual means by which HBV was passed from actual patients to actual patients, rather than theoretically so, and as such I **CONCLUDE** that the complainant has failed to prove that Dr. Dara actually harmed his patients. I **CONCLUDE** that the complainant has failed to prove that Dara engaged in any violation of standards that resulted in any of his patients acquiring HBV. Therefore, I am **UNABLE TO CONCLUDE** that the HBV that affected the several patients "stemmed" from or was "probably linked" to his practice, other than possibly due to the very fact of the patients' medical conditions and the chemotherapy treatments that they received from the doctor. Alternative explanations for why his patients have HBV and why several of them have the same strain of HBV appear to exist. While the evidence does not exist to prove that they actually provide the correct reason for what occurred (and I do not mean to imply the respondent bore any burden to prove them), nevertheless, given the lack of testing and background information against which to assess them and the deficiencies of the complainant's theory, they stand as other reasonable possibilities that cannot be dismissed as unwarranted. They are supported by credible and weighty expert opinion. [Bold appearing in the original]

**WE ADOPT** only that portion of the ALJ's summary of findings found in the ID at page 156 finding Respondent failed to adhere to professional standards, and we reject the remainder of the summary

which only finds respondent created the potential for harm to his vulnerable patients and which read as follows:

In summary, I CONCLUDE, that while charges that Dr. Dara actually caused harm to his patients have not been proven, his failure to adhere to professional standards regarding the supervision and control of elements of his practice has been established by a preponderance of the evidence. In this regard only, it is fair to conclude that he did permit the creation of potential risks to his vulnerable patients.

**WE HEREBY CONCUR** with and **ADOPT** the ALJ's finding that eleven (11) of Dr. Dara's patients contracted a genetically identical strain of HBV (ID at page 147) but **REJECT** the ALJ's suggestion that the finding regarding the CDC testing might not have confirmed conclusively the identity of the strain as follows:

And while I accept that the preponderance of the evidence is that the eleven had the same strain, even Khudyakov acknowledged that it is possible that there are differences between the virus that were not detected by the CDC's testing.

**WE REVERSE** the ALJ's dismissal of Count II as found in the ID on page 155 as follows:

I **FIND** that he did not either willfully or deliberately engage in any malpractice or gross malpractice in regard to these OSHA violations. This is not to excuse him as a matter of general law for a failure to properly deal with the laundry issue or for the storage of food in the wrong refrigerators (I make no finding that he knew of this, but that in and of itself is not critical) or the missing, or for a possibly mislaid, Exposure Plan. It is simply a recognition that, to the extent that Dara can even be said to have any responsibility for any of these violations, none is of such a character as to demonstrate the level of deviation from standards and unprofessional conduct that is implied in the characterization of something as professional malpractice, and certainly of "gross" malpractice.

Although the Board and the ALJ agree on two pivotal points 1 - Dr. Dara's office was rife with lapses in infection control due to his lack of oversight, and, 2 - eleven (11) of his patients were infected with a genetically identical strain of the HBV, - we reach vastly different conclusions, as to the import of these two crucial findings. We reach these divergent results because we bring to the undertaking a scientific perspective borne from our life-time of education and experience in medicine. We do not here overturn credibility findings of lay witnesses. But, we have reviewed the extensive expert testimony in the record through our lens as health care providers and reach a far different conclusion on credibility of the **expert testimony** and scientific proofs than that reached by a trier of fact with distinctly different training and expertise. The ALJ comes from a tradition and training that causes him to analyze this matter without utilizing scientific methodology and an understanding of causality in an epidemiologic context.

The Board in reaching the findings contained herein is mindful of the role that it has been given under N.J.S.A. 52:14b-10(e),

[i]n reviewing the decision of an administrative law judge, . . . [t]he agency head may not reject or modify any findings of fact as to issues of credibility of **lay witness testimony** unless it is first determined from a review of the record that the findings are arbitrary, capricious or unreasonable or are not supported by sufficient, competent, and credible evidence in the record. In rejecting or modifying any findings of fact, the agency head shall state with particularity the reasons for rejecting the findings and shall make new or modified findings supported by sufficient, competent, and credible evidence in the record [N.J.S.A.] 52:14b-10(c).1

(emphasis added)

Recognizing the particularized subject matter expertise of agencies, we believe the Legislature intentionally constructed this scheme to allow agencies to weigh and make final determinations as to the appropriateness and credibility of expert testimony. We exercise that responsibility in this matter and we base our rejection and modifications of findings on evidence in the record as follows:

**BREACHES IN INFECTION CONTROL**

**In regard to Count I, WE FIND** based on the record and our medical expertise that Respondent's office environment was rife with serious violations of standards of infection control and blood borne pathogens. We concur with the ALJ's finding "that Respondent failed to adhere to professional standards regarding the supervision and control of elements of his practice has been established" (ID at p. 156). However, we find Respondent's failures in that regard to be gross and repeated acts of negligence and malpractice, professional misconduct and a blatant abrogation of his ethical and professional responsibilities.

**UNSANITARY/DIRTY OFFICE**

**WE FIND** that respondent maintained an unsanitary office. We base our finding on the investigation team's observations and interviews of staff, chart review and photographs. The record revealed numerous breaches in infection control. The chemotherapy room had food and wrappers on the floor with multiple visible spots

of blood on the wall and floor (P-7, P-13, 3T at p. 174). The chemotherapy chairs were too close to each other, made of cloth and blood stained. (P-7, P-13, 10T at p. 145). Unwashed blankets were on chairs (P-7, P-13). A blood splatter was found on top of a mayo stand<sup>8</sup> containing blood drawing equipment (P-7, P-13, 4T at p. 58).

Unwrapped syringes were under the uncertified unclean chemotherapy hood.<sup>9</sup> (P-7, P-13, 6T at p. 4). Stored under the chemotherapy hood were medication vials, open syringes, including unmarked ones with fluid inside and other unsterile items, such as unwrapped saline bags and open single dose vials with handwritten dates on them. The utility room was the site of the Cell Dyn 1700 Blood Analyzer. Its drainage tube for blood effluent was situated in the sink where employees washed their hands (P-7, P-13). Dirty and clean<sup>10</sup> functions were being performed in the same area which created an opportunity for contamination. For instance, medicines were prepared in the utility room and the lab room where blood was drawn. Staff demonstrated a failure to change their gloves or wash hands between procedures in which it was likely they could come in contact

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<sup>8</sup>A mayo stand is a metal table used for medical instruments to be utilized in procedures.

<sup>9</sup>A chemotherapy hood is a sealed compartment where the chemotherapy drugs are prepared. It has a ventilation system designed to eliminate toxic fumes.

<sup>10</sup>Dirty in this context means related to blood or bodily fluids. Clean refers to functions such as the mixing of sterile medications.

with blood. Many procedures occurred in the chemotherapy room where patients' ports<sup>11</sup> were accessed, injections given and intravenous lines started. Dr. Dara allowed multiple severely deficient infection control practices to be the standard operating procedure in his office creating many opportunities for transmission of HBV.

#### ROUTINE OFFICE PROCEDURES AND CONDITIONS

Interviews conducted as part of the investigation revealed that the serious and multiple lapses were not exclusive to one day but were standard operating procedure in the office. Respondent explained the deplorable conditions revealed in the photographs exhibits (P-7) as a one day "snap shot" and not indicative of standard conditions in the office. Respondent contends that his nurse Suzanne Malta was called away to a family emergency and left the uncleaned chemotherapy room locked thinking no harm would occur as respondent was away on vacation and she would clean it before patients were treated, not knowing the investigation would take place the next day.

However, during the inspection staff advised Dr. Montana of office routines, identifying multiple lapses in infection control. For instance, it was standard practice to utilize single use

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<sup>11</sup>A port (or portacath) is a small medical appliance that is installed beneath the skin and connected to a vein in order for drugs to be inserted and blood samples drawn many times without the discomfort from repeated needle sticks.

medicine vials for multiple patients rather than for only one. In fact, the inspection team found syringes removed from their sterile package were left out and exposed making them susceptible to contamination. P-7 #18 shows four unlabeled filled syringes to be left in just such a condition. We find it axiomatic that allowing unwrapped syringes to be left in an area where blood is being processed - mixing of clean and dirty functions - can lead to contamination.

There was testimony that during observation of simulated patient care the nurses failed to change gloves after carrying out procedures during which they were likely to become contaminated with blood. Dr. Montana testified (6T at p.18) that Respondent's employees, demonstrated to the investigators how blood was routinely drawn. The alcohol did not dry as is necessary to sterilize the skin before the needle stick. This is essential in order to kill bacteria. The skin was also wiped with non-sterile gauze, kept at close proximity to speed the procedure. Demonstrations by staff also showed that the same gloves were worn by staff when drawing blood and then labeling tubes.<sup>12</sup> The gloves, now contaminated with blood, were placed in a communal basket where pens are kept. Wearing the same gloves, staff then performed the CBC blood test (ID 23-24). Employees stated that they routinely prepared a week's

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<sup>12</sup>When capping and uncapping a blood tube it is extremely common for blood to adhere to the cap and gloves can easily become contaminated.

worth of syringes, leaving them unwrapped, ready for use, on top of the Cell Dyn Blood Analyzer (P-7, P-13, 6T at p.15).

Another standard office practice, representing a serious breach of infection controlled protocols, involved the use of a single saline bag to flush the ports of multiple patients. If a nurse is wearing blood contaminated gloves and handles this saline bag it could become contaminated and serve as a source of HBV to patients whose ports are subsequently flushed. The use of a single saline bag to flush multiple patients is a prohibited practice in violation of CDC guidelines (5T at p. 187, 14T at pp. 150-151).

We wholeheartedly agree with Dr. Montana's opinion that these numerous breaches in infection control demonstrate a dangerous combining of dirty and clean duties in the same area, with the risk exacerbated by a lack of proper hand hygiene, resulting in a contaminated office (5T at pages 166 - 167). We do not base our finding on the condition of an unsanitary office on one day when an employee was called away unexpectedly. We base our finding on the staff's representations and demonstrations of standard practice in Dr. Dara's office that showed a prevalent and long standing disregard for accepted infection control standards. Their input corroborated that the conditions at the time of the inspection were not isolated. Many practices recognized to be standard operating procedure, were caught in the "snap shot."

**WE FIND** there was an outbreak of HBV in Dr. Dara's patient

population and an exact or specific date or mode of transmission is not a crucial element in establishing through an epidemiological investigation a public health outbreak. Proof of such an "element" might never be retrospectively available.

**CONTROL GROUP NOT NECESSARY TO DETERMINE OUTBREAK**

**WE REJECT** the ALJ's conclusion that a control group is necessary to determine whether an outbreak occurred. We reject the opinion of Respondent's expert who testified that there is a need for a control group in order to ascertain if there was an outbreak. (21T at p. 88). We recognize based on the testimony of the State's expert witness that the investigation was not an academic study or clinical trial. As Dr. Montana testified, the investigation of respondent's practice was an urgent response to a public health emergency (18T at p. 51). The CDC, the pre-eminent expert body in the field of epidemiology did not recommend use of a control group and control groups are not generally utilized in health department outbreak investigations (18T at p. 100). Furthermore, the public was at risk and the DHSS and CDS's goal was to identify a source and stop it from continuing to transmit disease to additional patients (5T at pp. 63 and 86). Additionally, the prevalence in the community is irrelevant because 11 patients had the identical DNA virus which would be a virtual impossibility to be found in a control group or in the community at large.

Although we could, we do not find it necessary to base our

finding of an outbreak on the greater number -twenty nine - patients infected in this case, as we could not agree more with Dr. Montana's statement that "No one should get HBV as a result of treatment in a practice" (18T at p. 46). Our conclusion that there was an outbreak for which Dr. Dara should be held accountable is not based merely on the snapshot of the conditions on the date of the inspection but on the State's expert testimony, testimony of staff and demonstrations of routine office procedures at Dr. Dara's office, coupled with the result that Dr. Dara's patients were infected with this dangerous blood borne pathogen, 11 of them with the identical virus strain. (P-15 through P-25, P-29, P-31, P-53; P-36, 9T, 10T).<sup>13</sup>

**PROOF OF EXACT MODE OF TRANSMISSION NOT NECESSARY FOR CAUSATION**

**FINDING**

The ALJ in reaching his decision, mistakenly relied on an assumption that there was no clear unequivocal connection between Dr. Dara's negligence, evidenced by gross and multiple lapses in infection control standards, and the actual transmission of HBV. ALJ Masin believes that the State must show the mode of transmission in order to support a finding that the patients were infected in his office. This underlying assumption is for the most part the underpinning for his opinion that Dr. Dara's culpability was not proved by a preponderance of evidence. In taking this stance, we

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<sup>13</sup>Although we could have based our findings on 29 patients we chose not to and base our findings on 11 patients of Dr. Dara's who have the identical DNA virus strain.

believe the ALJ demonstrated a fundamental misperception of the epidemiologic basis that we believe necessary to establish physician responsibility. In essence, he refused to appreciate scientific epidemiologic concepts of causal inference, that we accept by virtue of our training and experience. Physicians by necessity need to understand inference as they make decisions on a daily basis. We use facts, statistical associations and probabilities that may never be 100% complete and from them we draw conclusions and make decisions. Although the ALJ correctly identifies the standard of proof as the preponderance of credible evidence, at every opportunity it seems he requires much more. We believe that the epidemiologic findings in this matter clearly prove, by at least a preponderance of the evidence standard that Dr. Dara's practice was the source of this outbreak. ALJ Masin simply applied a standard not realistic in the context of this case and one that is inappropriate in relation to an epidemiologic investigation. Instead, he applied a standard more appropriate for a proceeding requiring a burden of proof approaching clear and convincing evidence or even beyond a reasonable doubt.

Epidemiologic investigations do not produce a direct line of evidence that ties exact action to outcome. Epidemiologic investigations are statistical, deal with probabilities and provide sufficient evidence to make sound causal inferences. It would be a virtually impossible burden for the State to prove what the ALJ

thinks is necessary - a precise link or event of transmission cannot be proved long after the event. It is not feasible to ascertain two (2) years after an occurrence which unsterile syringe, glove, blood splatter, or multiply-used saline bag caused the infection in each patient. The items were long ago disposed of and not available for laboratory testing. We are unable to ascertain if and when a nurse in Dr. Dara's office drew blood from an HBV positive patient and contaminated another syringe which was subsequently used to access another patient's chemotherapy port. We will never know if a nurse carrier using unclean gloves or improper hand washing practices transmitted the disease. However, because of the multiple infection control lapses which have been found, we do know that Dr. Dara's office was a fertile environment for transmission of HBV.

The Board has relied on the expert testimony of Drs. Montana, Farrer and Khudyakov in reaching this conclusion. The ALJ created a standard so high that the State could never stop a licensee from practicing, even in the face of a dangerous disease outbreak such as has been demonstrated here. We clearly do not know nor do we base our findings on the exact mode and date of transmission but find that any of the lapses found to exist in Respondent's office had the potential to cause transmission of a blood borne pathogen. The number of significant lapses increase that probability. Furthermore, the finding that (11) eleven patients contracted a genetically identical virus in circumstances where their only common exposure

was Dr. Dara's office leads us to find it highly probable - indeed, more probable than not - that the infection source in the disease outbreak present in this case, stems from Respondent's practice.

**ELEVEN PATIENTS WITH IDENTICAL VIRUS STRAIN**

**We Reject** respondent's alternate theories and **FIND** that because eleven (11) of Respondent's patients had the identical DNA strain of the virus infection, respondent's contention that the infection was a result of reactivation or any other theory proposed by Respondent is so implausible, that it cannot be deemed probable. It is most probable that the virus came from the same source and that source was almost certainly Respondent's office.

Yury Khudyakov, Ph.D. testified on behalf of the State as to the CDC and genetic sequencing. Dr. Khudyakov has been a scientist and researcher at the CDC for two decades. He is currently the Chief of Molecular Epidemiology and the Bioinformatics Laboratory. He has authored over 111 published scientific articles and is an expert in genetics and molecular virology (P-57). We relied on his expert testimony regarding the CDC's molecular sequencing to reach our conclusions.

The CDC conducted genetic sequencing of the HBV DNA in the patients' blood in order to ascertain the relatedness of the virus (14T at p. 63). Dr. Khudyakov described the extraction of DNA from the HBV virus. Generally, the HBV genome contains 3,200 nucleoside or base pairs. The sequence of the base pairs is determined and

compared to establish the relatedness of the viruses isolated from the various patients. After extraction of the DNA, it is amplified and multiple copies are made using polymerase chain reaction amplification. These amplified fragments were then sequenced and analyzed by computer and by witness, Dr. Khudyakov, Ph.D. (15T at p.59-60). This analysis resulted in the creation of phylogenetic trees, which through graphs demonstrate the relatedness of the specimens (15T at p.73). The CDC successfully analyzed 13 samples (15T at p.77) (others did not have sufficient DNA left.) The CDC sequenced the majority of the entire genome-2,882 base pairs on 8 samples and 1,900 base pairs on 5. The sequence analysis of almost the entire genome overwhelmingly revealed that eleven acute and chronic samples were 99.9% to 100% identical. Since there was no other common link between these patients the causal inference was that Dr. Dara's practice was a single exposure point to this specific virus. (14T at p. 67-68). We did not find the CDC's testing faulty or lacking as Respondent asserts. **WE FIND** the number of base pairs analyzed appropriate and the testing consistent with or exceeding accepted protocols.

We are of the firm conviction the only scientifically rational conclusion is that these patients had the genetically identical virus transmitted from one host to the next at Dr. Dara's practice. (15T at p.78) and we so **FIND**. Two (2) other samples tested were almost identical (99.6%-98.9%) and most likely linked because of the

epidemiologic finding and the rarity of the strain. The strain D2 is primarily found in the Middle East and Asia and rare in the United States<sup>14</sup>. **WE FIND** the genetic test results of the eleven (11) patients coupled with the findings of the epidemiological investigation confirm that it has been established that transmission of HBV occurred in Dr. Dara's office -it is certainly more probable than not. We, therefore, **FIND** that the genetically identical virus, with no other exposure common to all 11 patients other than treatment, at Respondent's office during the incubation period establishes an irrefutable epidemiological causal inference that proves the virus transmission is linked to Respondent's practice by substantially more than the preponderance of the credible evidence. We find the fact that eleven (11) patients treated at Dr. Dara's office contracted acute HBV from a genetically identical virus is incontrovertible evidence that there was an outbreak of acute HBV stemming from his practice.

#### **REJECTION OF RESPONDENT'S ALTERNATE THEORIES**

We find there is no other reasonable alternative theory for how these eleven (11) patients could contract a DNA identical virus and the specious explanations asserted by Respondent and his experts could not account for the transmission. We considered respondent's

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<sup>14</sup>This degree of identity also leads to a conclusion that these two (2) patients contracted the virus from the same link which would total 13 patients but we choose to base our finding on the (11) eleven patients with identical DNA.

alternative theories and conclude they do not absolve him of the inescapable conclusion that the outbreak of HBV amongst his patients stems from his office and that his lax education and enforcement of blood borne pathogen practices made this possible.

#### **REACTIVATION-IMPLAUSIBLE**

Reactivation is a phenomenon whereby a person who acquired the virus in the past - either with clinical HBV or subclinical disease - retains the dormant virus and when their immune system is suppressed it reactivates as an active HBV infection. The patient could have been originally infected decades earlier and anywhere in the world. We find this theory an implausible explanation for this outbreak because it is impossible for eleven (11) individuals who acquired the disease in different ways, different places and different times to reactivate with the identical DNA strain of the virus. We believe based on our medical expertise and the credible expert testimony in the record that the genetically identical virus in eleven (11) patients with no other common exposure other than Dr. Dara's office proves that his office was the source of transmission.

Dr. Montana testified as follows:

It was the same virus. This wasn't just the same type, it wasn't just a D, it wasn't just the same subtype, D2. This was identical virus, identical DNA sequences, identical genetic material, 99.9 to hundred percent identical. (T14 at pp. 68-69)

#### **CONTROL GROUP-INFEASIBLE AND UNNECESSARY**

Respondent asserts that a control group in Ocean County, New

Jersey, even a control group among oncological patients in that county, is necessary to determine the prevalence of the disease and strain. For the reasons cited on pages 20-21 herein we find this proposed requirement infeasible, irrelevant and unnecessary. **WE REJECT** the ALJ's finding (ID at p. 146) that an equally plausible explanation for the identical virus is that there is a larger pool of individuals with this identical DNA strain in the community who may have contracted the infection elsewhere. We reject this theory and find that the size of the D2 pool in the community is rendered irrelevant by the fact 11 of Dr. Dara's patients did not just have the virus subtype D2, they had the identical virus. A control group is not necessary in an outbreak investigation and is not a part of standard epidemiological practice.

**HBV WAS TRANSMITTED BY A NURSE CARRIER-IRRELEVANT**

The HBV was most probably transmitted by lapses in infection control in Respondent's office. It is simply irrelevant whether the lapses occurred from patient to patient or from nurse to patient or patient to nurse and then back to patient. The poor infection control practices in respondent's office are a two way street. They put both the patients and the staff at risk. If the myriad, significant breaches in infection control and blood borne pathogen standards did not exist then the opportunity for transmission would not exist.

Respondent asserts that the public health investigation was

faulty because the nurses were not tested. That claim is irrelevant to this matter. Even if a nurse was infected with the virus, it should not have been spread to the patients of the practice. The issue is the poor blood borne infection control practices and this physician's gross and repeated negligence and malpractice in not assuring that policies, training and education regarding proper standards were adhered to in his office.

#### **CONSPIRACY THEORY - IRRATIONAL**

Respondent's contention that employees/managers/nurses/others conspired against him by reporting him to OSHA, staging a dirty office and infecting cancer victims with HBV is simply not believable. The record clearly shows an office with rampant breaches in infection control existed and that there was ample opportunity for transmission of disease. Respondent's conspiracy theory does not present a plausible explanation for the outbreak we find linked to respondent's office.

#### **RESPONDENT'S EXPERT TESTIMONY**

Dr. Dara and his experts conceded they do not have the expertise in epidemiology, infection control or genetics and molecular virology that the State's experts possess (23T at p. 7). We relied on the competent credible expert testimony and documents entered into the record by the State which we found based on our own medical expertise far more credible and consistent with established scientific principle than Respondent's experts' presentations.

Respondent's witness Leon Smith, M.D. testified he was the first doctor in the State certified in Infectious Diseases and is also certified in Internal Medicine. He graduated from medical school in 1962 and has had a long successful career holding many titles, has been associated with St. Michael's Medical Center for fifty years and is a full professor in Microbiology and Public Health Preventative Medicine at New Jersey Medical School. He has trained hundreds of infectious disease physicians (R-32). He was accepted as an expert in Infectious Disease (ID at p.63, R-32).

In weighing his testimony we were cognizant of the fact that he was unaware of crucial information regarding the practices in Dr. Dara's office that hampered his ability to provide a reliable scientific opinion. Most importantly he did not know that the CDC had concluded that eleven (11) of the doctor's patients contracted the identical virus linked by transmission from host to host and conceded that genetics is not within his expertise (T19 at p.54). He thought that the patients had only been infected with the same type of virus not the same identical virus (19T at p.56 and 103). He had not been provided with the phylogenetic tree charts showing the 99.9% - 100% homology of the specimens (19T at p. 106), nor did he know that the CDC had sequenced almost the entire genome. He testified that environmental contamination is unlikely (ID at p.123, and pp. 144-145), and that contrary to the testimony of Respondent's other expert witness, Dr. Weisenthal and that of the State's

experts, Dr. Smith believes it was impossible for unwrapped syringes on top of the Cell Dyn machine to be a source of infection. (19T at p.70). Although he understood that the performance of invasive procedures increases the chance of transmission (19T at p.93), he did not appear to know that Dr. Dara's staff routinely performed invasive procedures on his patients (19T at p.93). Because he lacked essential information we accorded his opinion less weight and we also found it less credible than that of the State's experts.

Moreover we discounted the weight of the testimony of Respondent's second expert, Larry Weisenthal, M.D. He is an oncologist, who has not engaged in clinical practice since 1987 (21T at p.40, p.46) and was not qualified as an expert in epidemiology, infectious disease or genetics. He too did not receive all of the crucial relevant information in this case (21T at pp.82-84) and as a mentor of Dr. Dara's many years ago he appeared to exhibit a bias in favor of Respondent, as he testified:

...in my profession, one of the things that we point to is the people that we have trained and the people that we've mentored. And we would like to believe that the people we've mentored go on and have glorious careers that reflect positively on their mentoring. Conversely, if a person that we mentor goes onto have unprofessional performance, this reflects badly on us as well as badly on them. (24T at pp. 13-14)

Further Weisenthal's reliance on three scientific studies is inapt. He attempted to craft an alternative theory for the outbreak by citing studies that are rendered irrelevant by the finding that

Dr. Dara's patients were found to have an identical virus. The British Columbia Study, "Geno type D Amongst Injection Drug Users with Acute Hepatitis B Virus Infection" concludes that there was a cluster of the D3 virus in a high risk community. What Dr. Weisenthal failed to appreciate was in the British Columbia study the patients had the same D3 virus strain not the genetically identical D2 virus and in fact the patients did have risk factors. Thus the conclusions are not of relevance to the case at hand. (21T at pp. 129-130). He also misstated the relevance of the M D Anderson and Sloan Kettering Studies which show that there is a higher prevalence of HBV in oncology patients due to reactivation caused by immuno-suppression, (24T 32-33, 42-49, 56-57). He does not account for the fact that reactivation is not a plausible explanation when the patients have the identical DNA virus strain.

IN CONCLUSION **WE FIND** relying on the record and our medical expertise, that it is much more probable than not that the conditions in Dr. Dara's office caused an outbreak of HBV in his patient population and that the State, at the very least, has met the burden of proof by a preponderance of the credible evidence. That conclusion is in no way undermined by the finding in the studies Weisenthal relies upon.

#### **PRIOR OSHA VIOLATIONS**

In regard to Count II, **WE FIND** based on the record and our expertise that Dr. Dara was on notice since 2002 that he had

multiple lapses in infection and blood borne pathogen protocols as he had been sanctioned by OSHA in 2002, 2007 and 2008. We further **FIND** that because Dr. Dara was on notice that there were lapses in his office regarding these standards he should have been vigilant in guarding against any further infection control lapses and assuring his office staff adhered to proper protocols. We are not basing our finding on the severity of the 2002-2008 OSHA violations. Instead we find that because he had this history of violations directly related to infection control he should have asserted even more control over his office standards.

Instead, Respondent demonstrated almost a decade of documented history of poor infection control training and practice, profound neglect of blood borne pathogen prevention or a lackadaisical approach to addressing these matters despite three (3) separate warnings and substantial fines imposed in the many thousands of dollars by OSHA(P-43 through P-52). In his testimony (22T at p.19) Dr. Dara, the only physician practicing in his office, repeatedly claimed ignorance of the facts or deflected his responsibility onto others. He, as the physician, is responsible and his medical ethics and professional training should have motivated him to be aware and to rectify serious issues such as blood splattered on the wall of the infusion room and in phlebotomy trays, food and trash on the floor, and many unwrapped syringes routinely left exposed to contamination especially since his patient population is comprised

of particularly vulnerable cancer victims.

Despite his professional responsibility for the unsanitary conditions in his office, he claimed to be unaware of multiple serious lapses. He denied knowledge that standard office protocol was for his staff to use a single saline bag routinely on multiple patients daily. (20T at p. 190) Nor did he notice the saline bag hung under the chemotherapy hood (20T at p.192).<sup>15</sup> He even denied knowledge of the routine practice of piling of unwrapped pre-filled syringes with different solutions and medications stacked on the counter or under the supposedly sterile chemotherapy hood (20T at pp.192- 193, and pp. 231-232, 22T at pp. 17, 32 and 34) or the basket of syringes on the Cell DYN machine (20T at p. 205). He didn't notice the dirty and clean functions taking place in the utility room as he testified he had no reason to go in there (23T at p.85). He claimed ignorance of the fact of the breaches and he attempted to deflect his responsibility onto others for the violative practices in his office.

**WE FIND RESPONDENT** showed no insight even after a history of OSHA sanctions, nor recognition that his professional responsibilities as the practice owner and physician required that he oversee and ensure that safe infection control standards were in

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<sup>15</sup>The area under the chemotherapy hood is to be a clean environment for the mixing of medications and not a place to store items.

place.<sup>16</sup>

### CONCLUSIONS

In regard to Count I **WE FIND** based on competent, credible evidence in the record that Dr. Dara, whose patient population consisted primarily of immuno-suppressed cancer patients subject to invasive procedures, maintained an unsanitary office and failed to implement or ensure his employees implemented proper infection control practices. He countenanced practices that created an environment whereby his vulnerable patients were exposed to dangerous blood borne pathogens leading to infection of at least eleven (11) of whom all contracted the identical DNA strain of HBV.

In regard to Count II **WE FIND** based on competent, credible evidence in the record that respondent who is an employer of individuals who have occupational exposure to blood or other potentially infectious materials, has a history of being sanctioned by the (OSHA) for multiple violations of the Occupational Safety and Health Standards for Toxic and Hazardous Substances, 29 C.F.R. 1910 et seq., and its related statutes and implementing rules. We find that because he was on notice that there were lapses in his infection control practices he should have been even more vigilant in ensuring proper protocols were in place and supervising his employees in his medical practice, and that he repeatedly failed to

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<sup>16</sup>The New Jersey State Board of Nursing has jurisdiction over the nurse licensees. This Order shall be forwarded to that agency.

do so.

We **FIND** respondent's conduct in regard to Count I and II constitutes gross and repeated negligence and malpractice, in violation of N.J.S.A. 45:1-21(c) and (d); and professional misconduct, in violation of N.J.S.A. 45:1-21(e).

**PENALTY**

Upon consideration of the arguments of the parties, the testimony and documentary evidence presented at OAL, our own independent review of the record and most importantly because we found far more serious violations of standards of practice and violations of law than those found by the ALJ, we conclude that cause exists to modify the recommendation made by ALJ Masin as to penalty.

The Board is particularly concerned in this matter with Respondent's utter lack of or acceptance of responsibility that he is to blame for at least 11 and perhaps as many as 29 of his patients contracting HBV as a result of receiving medical care in his office - a result that should be a "never event." In his testimony, both at the Temporary Suspension Hearing and at the OAL, Respondent has attempted to place blame on others for the deplorable breaches of infection control protocols in his office. He blamed his employee, asserting a conspiracy theory in that the employee actually created

the dangerous situation. He blamed his nurses<sup>17</sup> for creating the multiple lapses, rather than recognizing that it his responsibility to create and assure compliance with protocols in his own office. We are struck by this physician's total disregard for the consequences of the unsanitary conditions he allowed to exist, before his eyes in his own office, where invasive procedures were being performed on cancer-stricken patients. Respondent continues to maintain he was not at fault and did not create the office conditions that we have found infected many of his patients with HBV. He steadfastly holds to this position, espousing a scientifically remote, if not impossible, theory of reactivation even in the face of a conclusive finding of eleven (11) patients found to have a genetically identical strain of the virus. We feel that the public would not be safe if he were to return to practice at this time, especially since he has not accepted the role that his actions or inactions played.

Confronted with the denial by Respondent, a physician and scientist, of responsibility for the conditions he allowed to exist, and the harm caused to many patients as a result of his cavalier attitude, **WE FIND** we have no alternative but to **MODIFY** the ALJ's finding on penalty and to impose the most severe penalty- revocation

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<sup>17</sup>We note the nurses have their own professional responsibility to meet appropriate standards of practice and we leave that issue to their licensing Board. However, any actions of the nurses do not diminish respondent's separate obligations.

of license. Yet, because we believe it was Respondent's gross and repeated negligence and malpractice and not his deliberate, willful acts that caused the violations found, we have crafted a pathway for him to re-enter practice. Re-entry is predicated upon his demonstration of retraining in infection control and ethical standards and demonstration of insight, along with a commitment to practice in a manner whereby he exercises absolute vigilance regarding safe practices. In addition, we retain the discretion upon any reinstatement to require that he work in a setting where he is not exclusively responsible for the practice's infection control standards. Respondent may apply for reinstatement of license four years after the start of the temporary suspension of license, and we hereby grant two and a half years credit for time out of practice already served.

We also impose far less of a monetary penalty than the State sought and the statute allows. The Attorney General sought civil penalties pursuant to N.J.S.A. 45:1-22 in the amount of \$10,000 for the first violation and \$20,000 for each subsequent violation found. If the penalties were based on the number of breaches found to have occurred or the number of patients infected as a result of those breaches the penalty would exceed over \$500,000.

However, we reach our determination after reviewing the mitigation testimony presented at the OAL. We have no doubt Respondent is well regarded by some of his colleagues, as portrayed

by several character witnesses who testified on his behalf at the mitigation hearing at OAL. We are also aware he has sustained considerable economic loss. We have therefore reduced the monetary penalties we would have otherwise imposed to \$30,000 based on the findings of numerous violations in this matter.

Additionally, Respondent shall pay reasonable costs to the State for prosecution of this matter to be assessed after the submission of the State's cost application and any response. Said application was to be submitted in writing by September 24, 2011 and Respondent's written reply to the Cost Application shall be due October 4, 2011. Respondent's motion for a stay of civil penalties and costs at this time is denied. However, at the time of consideration of the State's application for costs at the October meeting, Respondent may present certified financial records and renew his motion for a stay of the costs and penalties. The Board shall hold open the record in this matter for consideration of the cost submissions. The Board shall consider the matter of costs on the papers at its October 12, 2011 meeting.

**THEREFORE IT IS ON THIS 12th DAY OF October 2011,**

**ORDERED NUNC PRO TUNC, the oral announcement on the record on September 14, 2011:**

1. That the license of Respondent Parvez Dara, M.D. to practice medicine and surgery in the State of New Jersey be and hereby is revoked, effective immediately upon oral announcement on the record

on September 14, 2011.

2. Respondent may apply for reinstatement of his license four (4) years after the date of his temporary suspension of license, that is not before April 9, 2013.

3. Respondent has the burden, upon any application for reinstatement of license, to demonstrate to a Committee of the Board that he has learned what safeguards are to be implemented in managing an office by successful completion of re-education in infection control standards, blood borne pathogens, OSHA standards and medical ethics. The Board at that juncture would retain the discretion to determine a plan for re-entry to practice that is protective and may include supervision, monitoring or a setting where he is not responsible for infection control protocols.

4. Respondent within 30 days after the filing of this Order shall pay monetary penalties in the amount of \$30,000 made payable by certified check or money order and submitted to William Roeder, Executive Director, New Jersey Board of Medical Examiners, 140 East Front Street, P. O. Box 183, Trenton, New Jersey 08625.

5. Respondent shall abide by the Directives for Disciplined Licensees attached hereto and made a part hereof.

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

By: Kathryn C Lambert

Kathryn Lambert, D.O, Vice President