

FILED

February 11, 2015

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

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

In the matter of:

REZA FARHANGFAR, M.D.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon receipt of a report from the Medical Practitioner Review Panel (the "Panel") detailing findings and recommendations made by the Panel upon its completion of an investigation of information reported regarding a civil malpractice action brought by the estate of patient R.M. against respondent Reza Farhangfar, M.D. Specifically, the Panel received notification that a payment of \$775,000 was made on respondent's behalf to settle the civil malpractice action, wherein it had been alleged that respondent was responsible for a two to three year delay in the diagnosis of R.M.'s lung adenocarcinoma, which in turn resulted in a decreased chance of survival.

The Panel reviewed available information, to include information obtained from the reporting malpractice carrier, expert reports prepared during the pendency of the malpractice litigation and respondent's office medical record for patient R.M. The Panel also considered testimony offered by respondent when he appeared

for an investigative hearing on March 21, 2014, represented by Michael J. Keating, Esq.

The Panel found that respondent began treating R.M. for chronic obstructive pulmonary disease ("COPD") in May 2002, and saw R.M. regularly in his office for treatment of her COPD through June 2007. On February 29, 2004, an "ill defined 1.5 cm density" in the left lung base was identified on a CT scan of the abdomen and pelvis (the CT scan was performed as part of a work-up for a kidney stone). Based on that finding, Dr. Farhangfar ordered a CT scan of the chest and a PET scan. The CT scan of the chest, obtained on March 6, 2004, identified a "spiculated density . . . measuring approximately 2 cm in greatest diameter" in the left lung base. The PET scan report, dated March 11, 2004, found that the lesion was not FDG avid, however the report included a specific recommendation that "follow-up CT be obtained."

Dr. Farhangfar failed to order any further imaging studies to evaluate the nodule for a period of sixteen months, until an office visit on July 27, 2005. Dr. Farhangfar's office notes for R.M.'s July 27, 2005 office visit reflect that he then ordered a repeat CT scan, however that scan was not in fact performed. Dr. Farhangfar next saw R.M. in his office on October 25, 2005, at which time he decided not to re-order or further pursue obtaining a CT scan and instead ordered a chest x-ray.

The final report of the chest x-ray detailed that the previously identified lung nodule could not be visualized or identified. Nonetheless, that report, dated October 27, 2005, included a specific recommendation that the "previously described nodule at the left base would be better evaluated with a noncontrast CT scan of the chest." Dr. Farhangfar did not follow that recommendation, and thereafter did not order or obtain any additional follow-up studies until June 2007. RM was diagnosed with stage III non-small cell carcinoma of the lung in June 2007, and died in June 2009 with the immediate cause of her death identified as lung cancer.

The Panel concluded that respondent provided grossly negligent care to R.M. by failing to appropriately follow and perform additional testing to evaluate the spiculated lung nodule first identified on CT scan in March 2004. The Panel found that Dr. Farhangfar should have considered the nodule to be highly suspicious for malignancy, for reasons including the size and spiculation of the nodule, R.M.'s age (61 in March 2004) and a history which included previous smoking of up to 2 packs per day of cigarettes for a thirty year period (prior to stopping smoking in or about 1989). The Panel thus found that the standard of care dictated, at a minimum, that follow-up testing to evaluate the nodule be performed in or about March 2004, and that respondent's failure to order any follow-up imaging studies for sixteen months

(that is, from March 2004 through July 2005) was grossly negligent. The Panel additionally found that respondent's subsequent failure, between July 2005 and June 2007, to pursue obtaining the CT scan which he ordered in July 2005 (that is, after he learned that R.M. had not gone for the CT scan, and after he received a chest x-ray report in October 2005 which included a specific recommendation that a CT scan be obtained to evaluate R.M.'s lung nodule) supported a second and independent finding of gross negligence.

The Board has adopted all of the above delineated findings and conclusions of the Panel. Based thereon, the Board concludes that cause for disciplinary sanction against respondent exists pursuant to N.J.S.A. 45:1-21 (c) (engaging in gross negligence). Dr. Farhangfar neither admits nor contests the findings made herein. The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board being satisfied that the within disposition is adequate and appropriate, and that good cause exists for the entry of this Order:

IT IS on this 11th day of February, 2015

ORDERED and AGREED:

1. Respondent Reza Farhangfar, M.D. is hereby formally reprimanded for having engaged in gross negligence in his care of patient R.M., for the reasons detailed above.

2. Respondent is assessed a civil penalty in the amount of \$7,500, which penalty shall be due and payable in full at the time of entry of this Order.

3. Respondent shall, within six months of the date of entry of this Order, attend and successfully complete: (1) a course in the work-up and evaluation of solitary pulmonary nodules. Prior to commencing any course work to satisfy the requirements of this paragraph, respondent shall provide all available information concerning any course he proposes to take to the Medical Director of the Board, and shall obtain pre-approval, in writing, from the Medical Director for any proposed course. Respondent shall thereafter be responsible to ensure that documentation of successful completion of approved courses is forwarded by the course provider(s) to the Board. In the event that respondent fails to successfully complete the course work required herein within six months of the date of entry of this Order (specifically, if the Board does not receive documentation of successful completion of pre-approved courses within that time period), respondent shall be deemed to have failed to comply with the requirements of this Order, and his license may then be immediately suspended by the Board for failure to comply with the terms of this Order. In the event an Order of immediate suspension for failure to comply with the terms of this Order is entered, respondent's license shall thereafter continue to be actively suspended until

such time as he successfully completes the required course work, documentation thereof is submitted to the Board, and written notice of reinstatement is provided by the Board to respondent.

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

By: Stewart A. Berkowitz
Stewart A. Berkowitz, M.D.
Board President

I represent that I have carefully read and considered this Order, understand its terms, agree to comply with said terms and consent to the entry of the Order by the Board.

Reza Farhangfar
Reza Farhangfar, M.D.

Dated: 2/4/2015

Consent to the form of Order and to the entry of this Order by the Board.

Michael J. Keating
Michael J. Keating, Esq.
Counsel for Respondent

Dated: 2/10/15

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.