

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

In the matter of:

MARK D. CHASE, 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 following an investigation of care provided by respondent Mark D. Chase, M.D. to patient A.M. Specifically, the Panel initiated its investigation upon receipt of notification that a civil malpractice action brought by patient A.M. against respondent had been settled for \$100,000. The plaintiff alleged that Dr. Chase performed a hip replacement on the wrong hip, resulting in the need for additional surgery. The Panel reviewed available information concerning this matter; to include hospital records and testimony offered by respondent when he appeared, *pro se*, for an investigative hearing before the Panel on April 24, 2015.

Upon review of available information, the Panel found that on September 17, 2011, A.M., a 95 year old woman with dementia, presented to the emergency room with complaints of left

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hip pain subsequent to a fall. X-rays taken in the emergency room revealed a fracture to the left hip.

Dr. Chase testified before the Panel that he physically examined A.M. in the emergency room on September 18, 2011, at a time when no family was present. Respondent testified that on physical examination, he found A.M.'s right hip flexed and shortened, and found pain on both hips. Although respondent looked at A.M.'s x-rays, he mistakenly concluded that the right hip was broken. He then proceeded to mark A.M.'s right hip for surgery, and entered a brief note in the hospital chart stating "x-ray shows a displaced right subcapital hip fracture" and noting "assessment plan; right hip for hemiarthroplasty, risks/options outlined." Dr. Chase's hospital note did not memorialize his performance of a physical examination, nor include any findings made upon physical examination. Respondent thereafter obtained consent for the surgery from the patient's daughter.

On September 18, 2011, respondent took A.M. to the operating room for the planned procedure. Respondent recognized during the surgery that he was operating on the wrong hip, but then decided that it would present too great a risk to attempt to reverse the operation and instead completed the procedure.

When testifying before the Panel, respondent conceded that he did not review the intake note from the emergency room (recording that A.M. complained of pain to her left hip, and

memorializing a finding made on x-ray of a left hip fracture) or other available emergency room records which indicated that the fracture occurred on the left rather than the right hip. Respondent did point out, however, that the patient's x-rays were not available in the operating room for review prior to the procedure. Dr. Chase has accepted full culpability for having performed the wrong procedure, acknowledging that he marked the wrong operative site, obtained consent for the procedure to be performed on the wrong site, and then performed the procedure on the wrong side.

The Panel found that respondent engaged in gross negligence when he performed a right hip replacement on A.M., and found that the wrong sided surgery was clearly preventable had Dr. Chase exercised more diligence. The Panel also found, however, that systemic errors -- to include a breakdown in the hospital's "time out" protocol -- also contributed to the error. Finally, the Panel found as mitigating factors: 1) the fact that respondent was remorseful and accepted full responsibility for the mistake which occurred, and 2) that respondent made no effort to conceal his error or blame others, and immediately reported and acknowledged his error to the patient's daughters following the procedure.

The Board adopted all findings made by the Panel, and thus concludes that grounds for the imposition of disciplinary action exist pursuant to N.J.S.A. 45:1-21(b). The Board being

satisfied, on review of the entire record (to include consideration of the identified mitigating factors) that good cause exists for the entry of the within Order,

IT IS on this 8 day of Sept, 2015

ORDERED:

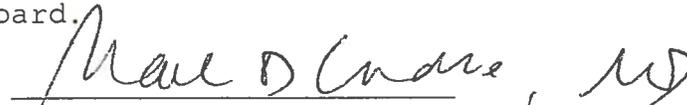
1. Respondent Mark D. Chase is hereby formally reprimanded for having engaged in gross negligence when he performed wrong-sided surgery on patient A.M.

NEW JERSEY STATE BOARD OF
MEDICAL EXAMINERS

By:


Stewart A. Berkowitz, M.D.
Board President

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


Mark D. Chase, M.D.

Dated:

9/1/15

**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.