

State Board of Medical Examiners
Open Disciplinary Minutes
March 10, 2004

A meeting of the New Jersey State Board of Medical Examiners was held on Wednesday, March 10, 2004 at the Richard J. Hughes Justice Complex, 25 Market Street, 4th Floor, Conference Center, Trenton, New Jersey for Disciplinary Matters Pending Conclusion, open to the public. The meeting was called to order by Mr. Glenn Farrell, Chairperson for Open Disciplinary Matters.

PRESENT

Board Members Criss, Farrell, Haddad, Huston, Lucas, Moussa, Paul, Patel, Perry, Ricketti, Robins, Rokosz, Trayner, Wallace, and Walsh.

EXCUSED

Board Members Chen, Desmond, Harrer, and Weiss.

ALSO PRESENT

Assistant Attorney General Joyce, Deputy Attorneys General Dick, Ehrenkrantz, Flanzman, Gelber, Hafner, Johnston, Kenny, Matthews, Levine, Warhaftig and Executive Director Roeder and Medical Director Gluck

RATIFICATION OF BOARD MINUTES

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE THE FEBRUARY 10, 2004 OPEN DISCIPLINARY BOARD MINUTES AS SUBMITTED WITH AMENDMENT NOTING THAT DR. HUSTON WAS PRESENT AND NOT ABSENT.

HEARINGS, PLEAS, RETURN DATES, APPEARANCES

**10:00 a.m. - DAITER, Eric, M.D. (License# MA 60374)
(DICK, Sandra Y., Counseling D.A.G.)**

**KERN, Steven I., Esq., for Respondent
JOHNSTON, Carol D.A.G. for Complainant**

Drs. Haddad, Rokosz & Wallace and D.A.G. Warhaftig were recused from discussion and vote in this matter.

This matter was set down for oral argument on exceptions in the matter of Eric Daiter, M.D. Enclosed for Board review was the December 10, 2003 Initial Decision of Administrative Law Judge John R. Tassini. The matter was initiated based upon a three-Count Administrative Complaint filed December 21, 1999 seeking the suspension or revocation of Dr. Daiter's license.

Also enclosed for Board consideration were the Administrative Complaint filed December 21, 1999; the Answer to the Administrative Complaint filed January 12, 2000; D.A.G. Johnston's Exceptions filed January 23, 2003; and Respondent's Written Exceptions filed January 23, 2004 to the Initial Decision. (Since many of the attachments to Mr. Kern's exceptions provide names, addresses and phone numbers of patients in their correspondence, the attachments were provided to the Board Members in their Closed Board packets.) Attached were additional letters of support for Dr. Daiter submitted by his counsel.

Also enclosed was D.A.G. Johnston's Application for Costs and Mr. Kern's March 4, 2004 letter to Executive Director Roeder with submission, for Board consideration, of Counsel's letter brief in Opposition to the Attorney General's application for an award of attorneys fees.

Chairman Farrell opened the meeting and after counsel placed their appearances on the record, Mr. Farrell indicated to the Court Reporter that during some of the transcription references and in the record, there are some patient names in full names being used. Mr. Farrell asked that during the course of the proceeding when any names are used, to please use initials. He further reminded counsel and Board members not to use any patient names in the record below.

Chairman Farrell noted to Mr. Kern from his submissions, that there were various letters from patients of Dr. Daiter and inquired as to counsel having any written waivers, since the Board has obligations with regard to confidentiality to those specific letters. Mr. Kern replied that there are no waivers, but that these patients sent in the letters knowing that they would be looked at and viewed by the Board, and they have obviously have no problem with it or they would have either not written or would have written anonymously. Chairman Farrell thought that the most appropriate mechanism would be to, of course, accept the letters, but directed Mr. Kern to redact the patients names within ten days to allow the Board to have complete record and redacted copy. Or he could obtain written waivers from the patients that have submitted the letters, thus carrying out the Board function of protecting patient confidentiality.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO HAVE THE PATIENT NAMES REDACTED FOR THE RECORD AND SENT TO THE BOARD OFFICE WITHIN TEN DAYS.

Chairman Farrell asked counsel if there were any preliminary matters before the hearing begins. Mr. Kern noted that there was one motion pending before the Board with regard to the certification of Nurse Christian and Chairman Farrell asked if there was a need for oral argument. Mr. Kern asked for three minutes to argue.

Mr. Kern argued that the Administrative Law Judge in this case had made numerous leaps of faith that were not supported by the record below. One of them involved assumptions concerning why a Preference Card of April 5, 1996 was created indicating sterile water arguing that this was not something that could have been have been contemplated because there was never anything in the record below concerning it. Mr. Kern continued to argue that since the Judge had made certain inferences that are contrary to fact, counsel thought it was important that the Board have the facts. The issue is whether or not Dr. Daiter participated in the April 5th creation of this card. It was never raised below and nobody ever suggested that he had participated in it and everyone knows that on April 10th, when he saw it, he immediately had it changed as indicated in part of the record below. Mr. Kern reiterated that this has come out of left field. He noted that Nurse Christian provide a Certification indicating what the usual methodology was. Nurse Christian had no specific direct recollection of something that occurred nearly eight year ago, but she knows what the method was and that was if you couldn't find the old Preference card, which was not an unusual event, you would create a new Preference card and you would use materials used at the prior case to create that card, and then discuss it with the surgeon when he next returned. S.D.A.G. Johnston objected as to this was a motion to submit this Certification to the Board and now Mr. Kern was summarizing the contents of the Certification, which has not been accepted for admission to the Board as yet. Chairman Farrell informed counsel that the Board would give some indulgence to counsel to submit his proffer.

Mr. Kern continued to argue that in any event, the Certification clarifies an issue that is unanswered, only because the, ALJ, among his many assumptions, made this one. Mr. Kern also informed the Board that Nurse Christian was, in fact, on the State's list of witnesses in the case below and it shouldn't be a surprise to the State.

The Sate argued that the Certification contains a very crucial statement. Nurse Christian has no recollection of the events of 1996, but then speculates about how certain things may have come about and reiterated that speculation from a fact witness is inappropriate testimony both before the ALJ and the Board. The Attorney General believed that while the Certification is relatively harmless, it does not contain information that is properly considered as evidence in this matter, and certainly not as evidence at this stage of the matter where the hearing has been completed, and thus is just not worthy evidence for the Board to consider.

Mr. Kern continued in his argument that the Certification is "not" speculation. He added that the words "may be" or "speculative" are nowhere in the Certification. What the statements say are based on usual practices of the operating room staff, the following probably occurred. He noted to the Board, for those who have read the

transcript, Judge Tassini took the position throughout the trial that the test of whether or not evidence was "admissible" was whether it was "probable" and this is clearly "probable". This is clearly probable and we're on a very low standard of proof, preponderance of proof, which is probability. All that this Certification says is, "it's probable that this is what happened".

The Board, upon Motion Made and Seconded, voted to go into Executive Session for Deliberations and Advice of Counsel. All Parties, except counseling staff, left the room.

The Board returned to open session and announced the following motion.

THE BOARD UPON MOTION MADE AND SECONDED, DENIED THE MOTION TO ADD THE STATEMENT OF NURSE CHRISTIAN AT THIS TIME. THE BOARD NOTED THAT THE RECORD IN THIS MATTER WAS CLOSED LONG AGO AND THE RULES OF THE OFFICE OF ADMINISTRATIVE LAW PROVIDE THAT A PARTY IS NOT PERMITTED TO INCLUDE EXTRA RECORD ITEMS, EVEN AT THE TIME OF EXCEPTIONS. THE BOARD ALSO NOTED THAT THE STATEMENT IS NOT A CERTIFICATION, BUT APPEARED TO BE A NOTARIZED STATEMENT. THE BOARD ALSO NOTED THAT THE MOTION WAS SUBMITTED UNTIMELY. AND FINALLY, THAT THE CERTIFICATION ITSELF INDICATES THE INDIVIDUAL HAD NO RECOLLECTION OF THE EVENTS IN QUESTION.

Chairman Farrell stated that the Board would now hear argument on Exceptions and informed each counsel had 20 minutes total and if they wished to reserve any time in rebuttal, he asked that they do so prior to argument.

Mr. Kern began his argument by asking the Board to reject the decision of the ALJ for one simple reason. According to Mr. Kern, the decision is not based on the evidence contained in the record, but rather it is based on speculation and assumptions which are contrary to the evidence and facts in reality. For example, Mr. Kern continued, the ALJ found at R7 that Dr. Daiter "did not write" that the use of sterile water "resulted from a nurse's error." "Consequently, in these circumstances, in violation of the standard of care, respondent knew or should have known that he was using sterile water as the distention medium." Referring to an article in the Star Ledger, dated Tuesday, February 24th, Mr. Kern noted that in New Jersey alone last year, there were 1,786 deaths in hospitals related to medical injuries. Of those, only three were reported to the State. Mr. Kern also reminded the Board that there is not a word of testimony in the record below that Dr. Daiter ever requested sterile water, nor is there any documentary evidence to suggest that Dr. Daiter intentionally used sterile water.

Mr. Kern continued by positing that the basis of the ALJ's Decision is limited to the following:

The first is the failure to record the nurse's error in the patient chart, which is well known to be a fallacy. And the second, is that Dr. Daiter somehow had some other duty to avoid using sterile water. Mr. Kern further argued that the ALJ himself contradicted his own findings, because at A8, he writes, "The AG then did not prove that the standard of care required the surgeon to check personally to confirm that the appropriate medium had been hung before infusing it." Well, Mr. Kern continued, if he didn't have to check it personally, and there is no testimony that he ever asked for it, how could he have ordered it intentionally. The ALJ also found that "prior to surgery, the hospital staff should prepare the OR consistent with the surgeon's choices, as shown on the preference card or computer record or as otherwise directed by the surgeon." R2.

Directing the Board's attention to the two cases at Riverview, Mr. Kern reminded the Board that the Judge opined that it should be set up according to the preference card. This is the preference card from Riverview, which was in use for the April 3 surgery. Beginning "11/22/95," the change made from "glycine" to "D5W 1000cc" "hysteroscopy." "Prefers" "D5W 1000cc." That's the preference card. That's the one that was in place on the date of the surgeries at Riverview (R-8A). Mr. Kern also noted that, without dispute, that the person responsible for hanging the fluid on that day was Nurse LeBron, a trainee. According to her testimony, a new nurse in training would do is with their preceptor, they would look at the preference cards, and the solution usually is already on the case card," as it was, as we have just seen. So when the doctor comes in the room, you will check with him as to what he wants to be infused." She continued by indicating that you check the preference card to verify that you have the necessary materials in the room. She could not recall whether Dr. Daiter was ever informed as to what was going to be infused. One could only conclude that Nurse LeBron hung the wrong stuff without Dr. Daiter

knowing. And even though Nurse LeBron testified that she was supposed to have a preceptor with her during all times, she admitted that when the sterile water was hung on April 3rd, she was the only one present to hang it, and the preceptor was no where to be found. That's what happened on April 3rd.

Mr. Kern also reminded the Board that dextrose and water is sometimes referred to as water. This was confirmed because two days after the incident at Kimball, Nancy Wollen, who's the Corporate Director of Peri-operative Services there, told Nurse Beradesco, that "sometimes surgeons will refer to dextrose and water as water."

At Riverview, Mr. Kern continued, after the cases on April 3rd, Dr. Daiter became aware that sterile water was used and he honestly and appropriately dictated sterile water. He did not return again to Riverview until April 10th, at which time he reviewed his preference card to make sure they had it right. He found that a new preference card had been created on April 5th. And as the testimony revealed, and as the exhibit clearly showed, before the case was done on April 10th, the very next case he did, the word "sterile water" is removed and 1000 milliliters "D5W" is replaced.

Mr. Kern further commented that from April 10th to the present, Dr. Daiter has never used anything other than D5W at Riverview. Why, if he would never use anything other than D5W at Riverview, why would he then intentionally use a different substance at Kimball? Mr. Kern posited that mistakes all too often happen in a hospital setting, despite people's best intentions. For example, Mr. Kern continued, Dr. Holly Roberts, an Ob-gyn who does hysteroscopy at Riverview testified that there were times when she had been given sterile water rather than glycine despite every effort that was made to avoid these kinds of errors, as late as 2000, nurses at Riverview were still making mistakes. It's a nursing error. It's not an intentional act by the doctor. These things unfortunately happen.

Referring to the preference card for Kimball that was in place on June 12th (R-9), Mr. Kern noted that it indicates one liter "5DW for hysteroscopy", which is supported by other testimony in the record. He pointed out that Nurse Lee testified that in order to determine what type of distending medium to be used during that operation, she recalled that the day before, she asked Dr. Daiter and he told her water, not sterile water. He also pointed out that the process in changing a preference card at Kimball occurred by writing the word "no", however, Mr. Kern noted, that nothing in the record indicates that this ever occurred. Additionally, Mr. Kern continued, the first assistant during the surgery testified that he did not hear any conversation whatsoever between Dr. Daiter and the nurses as to what distention medium that was to be used. Furthermore, Nurse Lee's testimony indicated that the only distention medium that she ever used or worked with in a hysteroscopy was sorbitol. Mr. Kern continued to argue by indicating that the only other testimony on this issue is from Dr. Damien. It's extraordinary, because Dr. Damien's own lawyer, John Zen Jackson, came in and breached attorney/client confidentiality under a narrow exception to that rule, when there is about to be a fraud perpetrated on the court. Dr. Damien, as you know, testified that Dr. Daiter intentionally used sterile water. However, Dr. Damien told his lawyer that Dr. Daiter never used – intended to use sterile water. And Mr. Zen Jackson breached the attorney/client confidentiality to avoid a fraud being perpetrated on the court. Mr. Kern question what the likelihood would be that he would have done so, if Dr. Daiter had intentionally used sterile water? This is also supported by the testimony of Bruce Patnser who testified that Dr. Damien never indicated to him that Dr. Damien thought that the patient's death was a result of any act by Dr. Daiter.

Finally, Mr. Kern addressed the issue of whether Dr. Daiter should have continued the hysteroscopy after the laparoscopy. There was an hour between the initial hysteroscopy when distention was lost and an attempt to return to hysteroscopy at about 1:00. The Judge found that "[i]f there is no symptom and/or vital sign of significant risk to the patient requiring that the hysteroscopy be terminated and requiring that the patient receive care for recovery and if it is determined that the volume of medium in the patient is not sufficient to constitute an unacceptable risk of harm, the surgeon may return to and/or continue and/or complete the hysteroscopy." It is undisputed, and the Judge determined that, "[a]t about 12:50 or 1:00 p.m., having no notice of a problematic clinical symptom, respondent returned to the hysteroscopy." He did what the ALJ said he should have done, he went back appropriately. The evidence showed that at 12:50, the second hysteroscopy is begun, and it's undisputed that there are only 500 cc's left in the second bag at that time when it's begun. When you only look at the perioperative report of Nurse Lee, there is only 500 cc's left in the second bag. According to the Judge's

findings, "for a routine hysteroscopy on a healthy, young patient, the nurse should assess the imbalance of medium at least every 15 minutes." Nurse Simonetti's testified that the Bag that was hanging at the time of the code at had been hanging for about five minutes and that she was surprised that there didn't seem to be as much in the bag as she would have thought because it was a 3,000 cc bag. Mr. Kern questioned how in five minutes after hanging the third bag, a code is called and the procedure is stopped, how that comports with the Judge's finding that you need to check every 15 minutes, and that Dr. Daiter failed to do so, is beyond understanding or comprehension.

And to be clear to a medical certainty of what happened, Mr. Kern directed the Board to review the testimony consisting of a report that was put in evidence of the State's own pathologist where he states that it was his opinion based upon the evidence and reports available, to a reasonable degree of medical certainty, that S.M. died of a large and rapid infusion of sterile water entering the intra-vascular space in the few minutes of the second hysteroscopic procedure. At the time the standard of care required monitoring every 15 minutes, according to Mr. Kern, and Dr. Daiter kept within the standard of care. He did nothing inappropriate. The Judge found it was appropriate to return to hysteroscopy, and all of this then happened within a few minutes.

He concluded by asking the Board to reject the ALJ's Initial Decision.

D.A.G. Johnston argued that Dr. Daiter challenges the credibility determinations that were made by the Administrative Law Judge. There was a lengthy hearing with many, many witnesses that the ALJ presided over, watched the witnesses' behavior and mannerisms as they testified, listened to hour after hour after hour of testimony, rendered a determination regarding credibility, who is telling an accurate story in all particulars, which parts are accurate, which parts cannot be accurate. And unfortunately for Dr. Daiter, she continued, the ALJ determined expressly that Dr. Daiter's hypothesis of nurse's error at two different hospitals on four different occasions, simply was not credible.

She continued by stating that the Judge expressly found that Nurses Lee and Berardesco were credible, and he found a number of other circumstances that supported his determination as to what really happened, or what his determination of what really happened was. Now this Board has the obligation to review these credibility determinations of the ALJ. And Dr. Daiter's attorney is presenting all that he can to try to find holes in the story that perhaps the ALJ did not credit to the extent that Dr. Daiter would have wanted the Judge to credit.

D.A.G. Johnston explained that there were, of course, a number of things in the record that supports the ALJ's determination of credibility. First, there is the fact that there are four incidents at two different hospitals in which the nurses report on three of the four incidents where he recognized he used sterile water for an operative hysteroscopy. She directed the Board's attention to Dr. Daiter's own expert, Dr. March, explaining that sterile water gives clarity of view because it disrupts the red blood cells, so if bleeding is started, the water bursts the cells. That's Dr. March's testimony on May 16, 2003, 9:30 a.m., page 27, lines three to ten. Similarly, D.A.G. Johnston pointed out that Dr. Brandwine testified that sterile water bursts blood cells, but D5W will not hemolyze blood cells. That's the May 7, 2003 transcript, 10:05 a.m., page 58, lines seven to nine. She continued to argue that there is nothing in the record whatsoever demonstrating that D5W gives a clearer picture than glycine. Two experts, Dr. Daiter's expert and the State's expert, both explained that the characteristics of sterile water bursts red blood cells and provides a very clear picture. Nurse Berardesco also testified on June 17, 2002, page 159, lines 24 and 25, that she herself was in an operating room while Dr. Daiter was performing an operation and that somebody poked their head into the room and asked Dr. Daiter, "what are you doing and what are you using." D.A.G. Johnston continued to explain that the Court was surprised at this. The testimony that indicated that Dr. Daiter said he was using water because he got a clearer picture.

Furthermore, D.A.G. Johnston argued that Dr. Daiter argued that the nurses were confused and that they thought water meant sterile water. She questioned how it was possible that nurses on four different occasions at two different hospitals were all confused. Rosemarie Lee, the circulating nurse at Kimball for June 11th and 12th, operative hysteroscopies, testified she always checked with the doctor as to what medium was wanted. She said Dr. Daiter asked for water. Significantly, Nurse Lee said that Daiter had also told her at one point in time, sometimes he uses D5 and W. Clearly Dr. Daiter knew the accurate term for D5 and W, and that was not the

term he used when Nurse Lee asked him what distention medium she should hang. Rather, he said water. If he wanted D5 and W, he would have asked for water. That transcript site is June 19, 2002, 9:15 a.m., page 86. And I can get the line for you, 15 and 16.

The ALJ found Mrs. Eve Damien credible – expressly found her credible when she testified that she overheard Dr. Daiter tell her husband that he asked for and used sterile water. The ALJ found Dr. Damien credible with regard to her statement that Dr. Daiter told him after the procedure that he'd asked for and used sterile water.

There is other testimony, according to D.A.G. Johnston, that further buttresses the ALJ's credibility finding. Kathleen Johnson, Director of Risk Management, testified that right after the code, Dr. Daiter told her "he used sterile water." He had used it before with no problem. That's June 17, 2002, the 10:00 a.m. transcript, page 197. This is supported by the testimony of JoAnn O'Connell, the Corporate Director for Standards, whereby she testified that Dr. Daiter told her he used sterile water and that he used it in the past without any problems." June 18, 2002 transcript, 9:15 a.m., page 90.

D.A.G. Johnston urged the Board to determine that the transcripts and the ALJ's reasoning and findings were abundantly supportive of his credibility determination.

With regard to the testimony that was presented about whether the nurses have made an error and hung sterile water for an operative hysteroscopy, she pointed out that the transcript cite at page — June 17, 2002, page 203, indicated not exactly what Mr. Kern's PowerPoint slide indicated. It said years ago some doctors may have referred – some doctors referred to dextrose and water as water, years ago. But we know that Dr. Daiter did not refer to dextrose – D5W as water. We know from the testimony that when he wants to indicate that D5andW or D5 and water, he knew exactly what he was doing. He's asking for D5 and water. When he asks for water, he's asking for something else.

With regard to the indication by Mr. Kern of Nurse Lee's June 19, 2002 testimony, that she'd only worked with Sorbitol, and therefore, she didn't know how to hang anything else, D.A.G. Johnston noted that in the ALJ's Decision at paragraph I8, Nurse Lee had indicated sterile water is stored in a different place, in the cystoscopy room. D5W is not even stored there. It did not make sense according to D.A.G. Johnston that a nurse would have been so confused that she would have gone to an entirely different room to get the distention medium that had been asked for.

In rebuttal to Dr. Daiter argument that the ALJ had determined that it was absolutely appropriate for him to return to the second hysteroscopy after being notified of a significant fluid imbalance, D.A.G. Johnston pointed out that the ALJ found no such thing. Rather, the ALJ found that the decision to do the second hysteroscopy by itself comprised gross malpractice and gross negligence. The suggestion that the ALJ thought that this decision was okay, D.a.G. Johnston argued, is not supported by the ALJ's decision.

Lastly, D.A.g. Johnston took exception with regard to the cause of death, which was the last slide that was presented to you, Dr. Krauss did not stop at the statement that was presented to the Board. She clarified by noting that in the ALJ's decision, Dr. Krauss indicated that the cause of death was fluid overload and/or water intoxication. She also noted that the ALJ also concluded that Dr. Daiter had already placed S.M. In grave danger before the hypothetical large and rapid infusion in the few minutes of the second hysteroscopy and water intoxication as a direct effect of respondent's infusion of sterile water as the distending medium.

D.A.g. Johnston reminded the Board that the Attorney General submitted exceptions, as well, in support of an argument for a more severe penalty, suggesting a revocation or a suspension of more than one year. The submission is based on the ALJ's numerous findings of gross malpractice, gross negligence and repeated acts of malpractice and negligence. Given the findings of the ALJ and the support in the record for these findings, D.A.G. Johnson urged the Board to revoke Dr. Daiter's license or, at the very least, impose a suspension for more than one year. She argued that Dr. Daiter departed from the training he received in medical school and the additional training he received when he joined Dr. Damien's medical practice, when he used, on several occasions, a distention medium that was exceptionally dangerous to the health of his patients. She stated that the Board has the authority and the responsibility to apply its own expertise and determine whether the violations

found and the credibility determinations made, warrant a penalty more substantial than a mere one year suspension.

Mr. Kern countered the Attorney General's argument by stating that he found it astonishing that in something as important as this, D.A.G. Johnston would intentionally misquote the record as she's done repeatedly. Referring to page 158 – 157, line 20. Mr. Kern quoted the record as stating: "When I went into the room and saw the hysteroscopy set up I saw that there was water hanging and I asked her are we using water?" She went on to clarify that she knew it was sterile water because it was imprinted on the bag. The nurse further remember, he continued, that she had been told that this was not the medium of choice and when she asked Rosemary Lee, she confirmed that she had asked Dr. Daiter.

Mr. Kern continued his argument by stating that the D.A.G. Johnston also told the Board that is a case of credibility. To the contrary, Mr. Kern believed this is a case about documentation and assumption. The documents all reveal D5W was the medium of choice. The nurse's all testified that they hung – they were supposed to hang what was on the preference card, and the only exception to that was Nurse Lee saying on the 11th, Dr. Daiter said water. Not sterile water, water. While D.A.G. Johnston would have the Board believe that Dr. Daiter told people he used sterile water and knew he used sterile water, but she fails to point out that it was only after he discovered that sterile water was used and he informed everyone subsequently not to use it again. It was a result of a one word mis-communication, the word "water." On the 11th, he dictated he used D5W, because he assumed he used D5W on the 11th. Why on the 11th would he dictate D5W if he intended to use sterile water? Especially since on April 3rd, when he found he used sterile water, he dictated sterile water. And on the 12th when he found he used sterile water, he dictated sterile water. He dictated honestly what he knew at the time he knew it.

Similarly, Mr. Kern continued by pointing out that both experts agreed that the fluid that entered this woman's body that caused her demise all occurred – all entered in the last few minutes of the procedure. There is no credibility issue there. There is no hypothetical. That is the only medical testimony in this record. And you're bound by the record, even though for some reason the ALJ didn't feel bound by the record.

Mr. Kern urged the Board to look very carefully at this record, to review the transcript. He suggested that the Board will not find a word in that transcript that Dr. Daiter ever requested sterile water.

In response, D.A.G. Johnston stated that the cause of death was fluid overload and/or water intoxication. The experts were in agreement that significant imbalances of distention fluid is a very serious and potentially dangerous condition. That's in the transcripts over and over again. It's in the ALJ's Decision over and over again.

With regard to the testimony and the transcripts, D.A.G. believed that the record would speak for itself. .

In conclusion, D.A.G. Johnston again stressed that this has been a very difficult case, and it is a very difficult case for this Board to consider as well. There are credibility determinations. There are two different stories being presented. There was a story by Dr. Daiter presented to the ALJ and to this Board. And then there is what the ALJ decided in his decision, that this Board is obligated to review, and determine whether it will accept, reject or modify. She submitted that the ALJ's determinations are fully supported by the record and that his findings should be affirmed in full.

The Board, upon motion made and seconded, voted to move into Executive Session for deliberations and advice of counsel. All parties, except counseling staff, left the room. At this time, Mr. Farrell left the proceedings.

The Board returned to Open Session and Dr. Robins noted for the record that he would be conducting the remainder of the hearing. The Board, having had the opportunity to deliberate in this case, announced the following motion.

THE BOARD, AFTER REVIEW OF THE RECORD AND UTILIZING IT'S EXPERTISE, ADOPTS THE FINDINGS OF FACT WITH THE EXCEPTION THAT THE BOARD IS MODIFYING R3, R5, R7, R9, R10, R13 AND R14, AS FOLLOWS:

IF YOU TURN TO PAGE 93, R3 IS MODIFIED AS FOLLOWS,

"RIVERVIEW'S PREFERENCE CARD ORIGINALLY SHOWED THAT RESPONDENT PREFERRED GLYCINE OR D5W AS THE OPERATIVE HYSTEROSCOPIC DISTENTION MEDIUM. HOWEVER, IN THE APRIL 3, 1996, RIVERVIEW OPERATIVE HYSTEROSCOPIES RESPONDENT PERFORMED ON C.U. AND A.H. HE USED STERILE WATER AS THE DISTENTION MEDIUM. RESPONDENT SHOWS THIS IN HIS OWN REPORTS, WHEREIN, HE WROTE THAT HE USED "STERILE WATER".

ELIMINATE THE REST OF THE SENTENCE, WHICH READ, "AND WHEREIN HE DID NOT WRITE, E.G., THAT HIS USE OF STERILE WATER RESULTED FROM A NURSE'S ERROR." AGAIN, THAT LAST PART IS ELIMINATED.

CONTINUING ON, THIS PART STAYS IN. "IT IS ALSO STATED IN THE NURSE'S 'INTRAOPERATIVE NURSE'S REPORT.' C-4; C-5. IT IS ALSO SHOWN BY NURSE CHRISTIAN'S WRITING '4/5/96 CC' AND 'STERILE WATER' ON RESPONDENT'S PREFERENCE CARD. C-5."

THIS IS AN ADDITION. DR. DAITER ACKNOWLEDGED THAT HE KNEW STERILE WATER HAD BEEN UTILIZED AT THE CONCLUSION OF THE FIRST CASE ON 4-3-96. (5/30/2003 TRANSCRIPT, PAGES 184 AND FOLLOWING).

GIVEN ALL THE CIRCUMSTANCES, THE BOARD FOUND THAT WHEN DR. DAITER BECAME AWARE AT THE CONCLUSION OF THE FIRST CASE AT RIVERVIEW THAT STERILE WATER WAS UTILIZED, HE HAD AN OBLIGATION TO ABSOLUTELY ENSURE THAT THE CORRECT DISTENTION MEDIUM WAS HUNG AND UTILIZED. HE FAILED TO DO SO IN VIOLATION OF THE STANDARD OF CARE.

THE REMAINDER OF THE TYPEWRITTEN FINDING OF FACT R3 IS ELIMINATED.

R5 IS MODIFIED AS FOLLOWS: THE FINDING STANDS FOR THE FIRST EIGHT LINES UP UNTIL THE WORDS "CREDIBLE" AFTER WHICH THERE SHALL BE A PERIOD. AND AGAIN, THE BOARD IS STRIKING LANGUAGE THAT FOLLOWS THAT AND STRIKING THE FOLLOWING: "AND I FIND THAT, IN VIOLATION OF THE STANDARD OF CARE, RESPONDENT REQUESTED AND KNEW THAT HE WAS USING STERILE WATER AS THE DISTENTION MEDIUM FOR D.D.'S HYSTEROSCOPY."

THE BOARD IS SUBSTITUTING THE FOLLOWING: WE FIND RESPONDENT WAS IN VIOLATION OF THE STANDARD OF CARE FOR NOT ASSURING THAT HE WAS USING D5W, OR THE APPROPRIATE DISTENTION MEDIUM, AFTER HIS AWARENESS OF THE RIVERVIEW INCIDENTS AND OF HIS USE OF STERILE WATER IN THE PRIOR HYSTEROSCOPIES.

R7 IS MODIFIED AS FOLLOWS: "ON JUNE 12, 1996," STRIKE "CONSISTENT WITH RESPONDENT'S DIRECTION THE DAY BEFORE RELATIVE TO D.D.'S HYSTEROSCOPY," SO IT WILL READ, "ON JUNE 12, 1996," "THE NURSE AGAIN HUNG STERILE WATER AS THE HYSTEROSCOPIC DISTENTION MEDIUM FOR S.M.'S HYSTEROSCOPY."

STRIKE THE NEXT SENTENCE ENTIRELY, THAT IS, "RESPONDENT KNEW OR SHOULD HAVE KNOWN THAT HE WAS USING STERILE WATER AS THE DISTENTION MEDIUM FOR S.M.'S HYSTEROSCOPY." THAT WAS THE SENTENCE THAT WAS STRICKEN.

THE FINDING CONTINUES: "RESPONDENT ASSEMBLED THE RESECTOSCOPE, WHICH WAS CONNECTED TO THE BAG OF STERILE WATER, AND HE DID NOT PERSONALLY CONFIRM THE IDENTITY OF THE MEDIUM. IN RESPONDENT'S 'PROGRESS NOTES' RELATIVE TO S.M.'S CASE, HE USED THE TERM 'WATER' FOR STERILE WATER USED AS THE DISTENTION MEDIUM." STRIKE THE REMINDER OF THAT SENTENCE, WHICH WAS, "AND HE DID NOT WRITE, E.G., THAT THIS RESULTED FROM A NURSE'S ERROR," INCLUDE THE J-1 REFERENCE, HOWEVER.

AND THE BOARD ADDS, AFTER THE RIVERVIEW INCIDENTS AND WITH HIS AWARENESS OF THE USE OF STERILE WATER IN HIS PRIOR HYSTEROSCOPIES, RESPONDENT HAD AN OBLIGATION TO ABSOLUTELY ENSURE THAT THE CORRECT DISTENTION MEDIUM WAS HUNG AND UTILIZED.

"CONSEQUENTLY, IN THESE CIRCUMSTANCES, IN VIOLATION OF THE STANDARD OF CARE," RESPONDENT FAILED TO ENSURE THAT THE CORRECT DISTENTION MEDIUM WAS UTILIZED.

R9 WILL REMAIN THE SAME EXCEPT FOR ONE CHANGE AT THE BOTTOM OF PAGE 95, STARTING WITH NUMBER (1) WHERE IT READS, "THE SURGEON." IT'S THE SECOND TO LAST LINE OF THE PAGE. "(1)" WILL BE ELIMINATED AS IT APPEARS IN THE ALJ'S DECISION, AND READ AS FOLLOWS: THE SURGEON SHOULD BE AWARE OF THE PATIENT'S STATUS AT ALL TIMES.

R10 WILL REMAIN THE SAME WITH THE FOLLOWING MODIFICATION ON THE SECOND TO LAST LINE OF R10. BEFORE THE FIRST WORD "SYMPTOM," IT SHOULD READ SIGNS AND/OR SYMPTOMS. OTHERWISE, R-10 REMAINS THE SAME.

R13 WILL BE READ AS IT APPEARS; HOWEVER, MODIFIED AS FOLLOWS: STRIKE THE ENTIRE SECOND SENTENCE, WHICH READS, "HE DID NOT". ALSO, WRITE E.G., THAT A NURSE HAD HUNG IT CONTRARY TO HIS INSTRUCTION."

IN ADDITION, AFTER THE DISCUSSION REGARDING DR. DAMIEN AND MRS. DAMIEN, AFTER THE WORDS "STERILE WATER," ADD THE FOLLOWING SENTENCES: TESTIMONY OF OTHER WITNESSES, INCLUDING RISK MANAGER JOHNSON, ARRIVING DURING THE INCIDENT, AND JOANN O'CONNELL, SUPPORT THE CONCLUSION THAT DR. DAITER WAS AWARE HE WAS USING STERILE WATER.

IN ADDITION, THE NEXT SENTENCE THAT APPEARS – "THAT IS, I FIND THAT IN VIOLATION OF THE STANDARD OF CARE, RESPONDENT REQUESTED AND" – THE ADDITION IS "/OR." SO IT WILL READ, REQUESTED AND/OR "KNEW THAT HE WAS USING STERILE WATER AS THE DISTENTION MEDIUM," ETC. THE REST OF THE FINDING OF FACT REMAINS AS IS.

R14, THERE WILL BE ONE CHANGE ON THE FIFTH LINE, THE SECOND WORD, THE WORD "CHOICE" WILL BE CHANGED TO "USE."

THE BOARD ALSO ADOPTS THE CONCLUSIONS OF LAW, EXCEPT THE BOARD MODIFIES AS FOLLOWS, ON PAGES 102 AND 103.

THE SECOND PARAGRAPH WILL READ AS FOLLOWS: "RELATIVE TO THE COMPLAINT'S COUNT I, CONSISTENT WITH THE ABOVE-DESCRIBED FINDINGS OF FACT, ON APRIL 3, 1996, AT RIVERVIEW," AFTER PERFORMING THE OPERATIVE HYSTEROSCOPY ON PATIENT C.U., RESPONDENT FAILED TO ENSURE THAT THE APPROPRIATE DISTENTION MEDIUM WAS USED FOR PATIENT A.H., "IN VIOLATION OF THE STANDARD OF CARE, THEREBY SUBJECTING THE PATIENT TO UNNECESSARY DANGER."

PARAGRAPH 3 IS MODIFIED AS FOLLOWS – IT WILL READ AS FOLLOWS: "RELATIVE TO THE COMPLAINT'S COUNT II, CONSISTENT WITH THE ABOVE-DESCRIBED FINDINGS OF FACT ON JUNE 11, 1996, AT KIMBALL, IN PERFORMING THE OPERATIVE HYSTEROSCOPY ON PATIENT D.D.," RESPONDENT, AFTER HIS AWARENESS OF THE RIVERVIEW INCIDENTS AND OF HIS USE OF STERILE WATER IN HIS PRIOR HYSTEROSCOPIES, FAILED IN HIS OBLIGATION TO ENSURE THE APPROPRIATE DISTENTION MEDIUM WAS UTILIZED, "IN VIOLATION OF THE STANDARD OF CARE, THEREBY SUBJECTING THE PATIENT TO UNNECESSARY DANGER."

THE FOURTH PARAGRAPH WILL BE MODIFIED AS FOLLOWS: "RELATIVE TO THE COMPLAINT'S COUNT III, CONSISTENT WITH THE ABOVE-DESCRIBED FINDINGS OF FACT, ON JUNE 12, 1996, AT

KIMBALL, IN PERFORMING THE OPERATIVE HYSTEROSCOPY ON PATIENT S.M.," RESPONDENT, AFTER HIS AWARENESS OF THE RIVERVIEW INCIDENTS, AND OF HIS USE OF STERILE WATER IN HIS PRIOR HYSTEROSCOPIES, FAILED IN HIS OBLIGATION TO ENSURE THE APPROPRIATE DISTENTION MEDIUM WAS UTILIZED, "IN VIOLATION OF THE STANDARD OF CARE, THEREBY SUBJECTING THE PATIENT TO UNNECESSARY DANGER." FURTHER, AFTER THE NURSE NOTIFIED RESPONDENT OF APPARENT SIGNIFICANT MEDIUM IMBALANCE, HE INFUSED ADDITIONAL STERILE WATER INCREASING THE DANGER.

FINALLY, THE FINDINGS OF FACT AND CONCLUSIONS OF LAW HAVE BEEN CONSIDERED AND ADOPTED AS THE BOARD HAS INDICATED MODIFIED UP TO THE NINTH LINE OF PAGE 103. AT THE END OF THAT SENTENCE THERE, AT THE END OF THE CITATION OF N.J.S.A. 45:1-21 (e), THE REMAINDER OF WHAT IS WRITTEN AFTER THAT CONCERNS THE PENALTY. AND CONSIDERATION OF THOSE PARAGRAPHS WILL BE DEFERRED UNTIL THE MITIGATION PHASE.

The Board then conducted a mitigation hearing.

Ms. Jodeen Kramer, a bookkeeper at her husband's food brokerage company and former elementary school teacher, testified that she met Dr. Daiter approximately a year ago. She first learned about him when she was doing some internet based research on infertility and found his website to be extremely informative. She was surprised at the amount of time that he spent with her during her first appointment, thoroughly reviewing her medical history of herself and her husband. Ms. Kramer also stated that he was very compassionate and sensitive. Given his understanding of their desire to start a family, Ms. Kramer stated that she wanted to continue seeing him. According to Ms. Kramer, she has unconditionally recommended him to others and even knowing about the allegations of the Attorney General and findings of the Administrative Law Judge, she maintained that he is a phenomenal doctor who always has his patient's best interest at heart. She also talked about how to have her sessions with him interrupted at this time would create a real hardship for her and her husband. According to Ms. Kramer, finding a Board Certified Reproductive endocrinologist in her area is difficult because there aren't that many in the Middlesex, Monmouth County Area. Because she has developed a relationship with Dr. Daiter over the past year, if her treatments had to be stopped even temporarily, she would have to start all over again. And for somebody of her age and in her position, with the type of treatment she is seeking, having infertility treatments stopped she believed would create a real hardship. Ms. Kramer was convinced that Dr. Daiter would never do anything malicious or harmful to a patient.

Dr. Magdalena Anisko was then called as a witness. After being sworn in, she testified that she is a pediatrician with a solo practice in Cranford, New Jersey. Her husband is also in a solo practice as an internist. She recalled that about a year ago, she became a patient of Dr. Daiter's because she was having some medical problems. After consulting a number of specialists in various fields, no one seemed to be able to help her. She began to ask around, especially seeking information from her patients, and consistently people urged her to make an appointment with Dr. Daiter. Dr. Anisko was immediately impressed on her first appointment with the amount of time that Dr. Daiter spent with her. She has always found him to be compassionate, friendly, and in particular, extremely knowledgeable. After many years of not having a proper diagnosis, it was only through the help of Dr. Daiter that she is finally recovering. She stated that she would unconditionally recommend Dr. Daiter.

The next witness, Dr. Joseph Sestito, addressed the Board. Dr. Sestito is an anesthesiology at Riverview Medical Center in Red Bank. He became acquainted with Dr. Daiter as an operating surgeon. He testified that he has observed him to be a very methodical and exact physician. Dr. Daiter, according to Dr. Sestito, keeps to a routine and is well respected within the hospital. He indicated that as a result of the incident in 1996, Riverview now requires that the nurses monitor the I's and O's and give that to the operating surgeons at the end of the hysteroscopy. Dr. Sestito also has had the opportunity to observe Dr. Daiter with his patients and their families and always has found him to be compassionate and caring, spending as much time as they need him. He referred his wife to Dr. Daiter for some infertility problems.

Dr. Russell R. Hoffman was called as a witness next. Dr. Hoffman, an obstetrician and gynecologist, maintains a practice in Summit, New Jersey. As a general rule, he only performs diagnostic hysteroscopies. He initially came

to know Dr. Daiter through some mailings that Dr. Daiter did when he was starting up his practice. At that time, according to Dr. Hoffman, he was attempting to expand his practice to include infertility and he contacted Dr. Daiter. Dr. Hoffman testified that he has referred patients to Dr. Daiter and has never heard anything negative about Dr. Daiter in the feedback he has received. Hearing such positive comments, Dr. Hoffman introduced Dr. Daiter to Overlook Hospital. Dr. Hoffman opined that an interruption in Dr. Daiter's practice would have a horrendous impact on his patients.

Dr. Josephine Filardo testified and informed the Board that she has been practicing obstetrics and gynecology for the past fourteen years. She continued by stating that she came to know Dr. Daiter sometime in 1993 when he joined their group practice. Almost immediately, Dr. Filardo began to refer patients to Dr. Daiter and the overwhelming number of the patients were very pleased with Dr. Daiter. Dr. Filardo also has had an opportunity to serve as a first assist in surgery with Dr. Daiter and has observed him. She described him as an exceptional surgeon who exudes a sense of security and confidence. At the same time, according to Dr. Filardo, Dr. Daiter has the ability to make the other in the operating room to feel at ease. Even learning about the allegations and decision made by the Administrative Law Judge, Dr. Filardo testified that she would continue to recommend patients to Dr. Daiter without question. She too believed that if Dr. Daiter's practice were interrupted even for a small period of time, the impact on his patients, as well as those future referrals from her, would be enormous.

Although Ms. Weir did not call any other witnesses, she reminded the Board of the countless letters of support that had been submitted on Dr. Daiter's behalf.

Dr. Daiter addressed the Board and stated that no matter what the Board decided, it could not compare with the agony that he has felt over the years knowing that a patient of his has died while under his care. He assured the Board that he has gone over and over the details of this case everyday and attempts to figure out the steps that could have been taken to avoid such a tragedy. He continued by explaining that he understood that the Administrative Law Judge suggested that he need time off to reflect upon this case some more. He assured the Board that he has altered his practice patterns to be certain, or as certain as possible, that every procedure is performed in the way that it's supposed to be, placing his patient's safety above all else. He did not believe that time off would increase his vigilance or his remorse. He further assured the Board that her death has resulted in a safer and more careful environment for every woman undergoing hysteroscopic surgery, whether by him or someone else. New procedure and protocols, many of which he helped to draft and implement at the local hospitals, new equipment and greater diligence by the OR personnel, are all a result of this death and the death of a few other women across the country at about this time while undergoing hysteroscopic surgery. Dr. Daiter also stated that in his own practice he now confirms the identity of every bag of fluid that is hung and that he only uses one liter bags of distention medium, calculating the deficit after every liter used and he stops the procedure if he can't account for more than one liter of fluid. Since this tragedy, nearly eight years ago, he has performed over 500 similar operative hysteroscopy procedures and he assured the Board that every one was performed with the utmost diligence, enormous care and total devotion to the safety and well-being of my patients. There has not been another incident, even a minor one, affecting patient safety since that time.

In his closing argument, Mr. Kern recalled that he was at a meeting in Phoenix over the weekend of the Society of Pediatric Anesthesia and the key note speaker was Dr. Leape out of Harvard who talked about Medical Errors in a Hospital Setting. During his speech, Dr. Leape recounted reports of the 96,000 to 98,000 avoidable medical errors resulting in death each year. He talked about really ten million injuries that occur in hospitals as a result of medical errors each year. And what struck Mr. Kern most is that at the end of his discussion, he polled the audience of anesthesiologists and asked them how many of you have been personally involved in a medical error which resulted in a death, 42 percent answered yes.

Mr Kern acknowledged that whenever a death or injury occurs, it is a tragedy, generally a system tragedy. Mr. Kern continued, however, by pointing out that the Board cannot make the tragedy go away or better by trying to point a finger and casting blame at an individual. He stated that we are all human and that we all err. As tempting as it may be, the Board cannot eliminate errors by taking away a doctor's license when he commits an error.

Mr. Kern reminded the Board that it had in excess of 200 letters from patients, all of these people in the room,

who attested to the quality and the caring of this particular doctor. He's highly trained. He's well respected. And in his years of practice, he's had one incident. That was the incident eight years ago. He has had a pristine record since. He requested that the Board put that one case in context. Hysteroscopy eight years ago, as is indicated in the record, was very different than hysteroscopy today. Mr. Kern related a prior experience from Beth Israel in New York where a woman died of a hysteroscopy. And in the course of investigating that case and what went wrong, experiments were conducted and in fact, Dr. Richard Traystman, who appeared in this case, perhaps the world most foremost physiologist out of the John's Hopkins, head of the Department of Critical Care, participated in the investigation. It was during this investigation that it was discovered that one can instill three liter of fluid into a patient through venous sinus in well under five minutes. Yet the monitoring requirements at that time, as evidenced in the record, were that one is to check fluid balance every 15 minutes.

The simple fact of the matter, according to Mr. Kern, is nobody realized the risk involved in what appeared to be a relatively benign procedure until a couple of these tragedies occurred. And everybody then went and looked and investigated, created hospital protocols, which up until that point existed virtually nowhere, and changed the way hysteroscopy was done. Today we have equipment which monitors input and outflow. We have protocols to deal with these issues. None of this existed in 1996.

He asked the Board not to judge Dr. Daiter by today's standard but by the standard that existed for hysteroscopy in 1996. He was at the wrong time, at the wrong place and a horrible thing happened. It doesn't make him a bad doctor. If anything, perhaps ironically, it's made him a far better doctor.

Mr. Kern urged the Board to allow Dr. Daiter to continue to practice, to continue to do his good work and allow him to care for his patients as he needs and wants to do.

In her closing remarks, D.A.G. Johnston, reminded the Board that this is the mitigation phase of this proceeding. Insofar as this is just an implication that Dr. Daiter may not have violated the standard of care in 1996, she noted that the Board has an entire trial about the standard of care in 1996. The Administrative Law Judge was very careful, as the Board has seen in the transcripts, to make sure that each testifying expert was pinpointing his testimony to the practice in 1996. The findings that the ALJ made regarding the standard of care were attuned to 1996 and this Board's adoption of those findings, those ones that were not modified, should be taken into account at this time.

D.A.G. recognized there are a number of people in attendance at the hearing who think very highly of Dr. Daiter. There is not very much the AG can do to address that except to recognize that there are a number of people who took their time out of their day. However, she continued, the Attorney General requested that the Board look at the record, look at its findings, look at the number of different incidents that underly this case. It's not just one. It's not just two. It's not just three. She was confident that based on all the evidence submitted, the Board was capable of making the appropriate penalty that fits this conduct.

The Board, upon motion made and seconded, voted to go into executive session for deliberations and advice of counsel. All parties, except counseling staff, left the room.

The Board returned to open session and announced the following motion.

THE BOARD, UPON MOTION MADE AND SECONDED, BASED ON THE MODIFICATIONS OF THE FINDINGS OF FACT IMPLEMENTED BY THE BOARD TODAY, AND AFTER CONSIDERING THE EXCEPTIONS AND MITIGATION PRESENTED, VOTED TO MODIFY THE CONSIDERATION AND ORDER OF THE ADMINISTRATIVE LAW JUDGE AS TO PENALTY AS FOLLOWS:

FIRST, ON PAGE 103 OF THE INITIAL DECISION, THE FIRST FULL PARAGRAPH, LAST SENTENCE, IS ELIMINATED BY THE BOARD. THAT SENTENCE READ, "SUSPENSION OF HIS LICENSE WOULD ALLOW HIM TIME TO CONSIDER HIS CULPABILITY AND TO CONSIDER METHODS OF IMPROVEMENT OF HIS PRACTICE TO AVOID ANOTHER TRAGEDY."

The Board further modified the penalty as follows:

THE LICENSE OF RESPONDENT IS SUSPENDED FOR A PERIOD OF ONE YEAR; NINE MONTHS OF WHICH IS ENTIRELY STAYED, THREE MONTHS OF WHICH SHALL BE SERVED AS AN ACTIVE SUSPENSION. IN ORDER TO MINIMIZE THE IMPACT ON PATIENTS CURRENTLY IN TREATMENT, THAT THE THREE MONTH PERIOD OF ACTIVE SUSPENSION IMPOSED SHALL BE SERVED AT THE END OF THE ONE YEAR PERIOD, THAT IS, IT SHALL BE SERVED DURING THE LAST THREE MONTHS OF THE ONE YEAR PERIOD.

RESPONDENT SHALL PAY MONETARY PENALTIES AS FOLLOWS, IN ACCORDANCE WITH THE PRIOR VERSION OF N.J.S.A. 45:1-21, ENTIRELY IMPOSED AS FIRST OFFENSE PENALTIES FOR COUNT I, \$2500; COUNT II, \$2500; COUNT III, \$2500; FOR A TOTAL OF \$7500 IN MONETARY PENALTIES.

RESPONDENT SHALL PAY COSTS AS FOLLOWS: \$26,770.69 IN TRANSCRIPT COSTS; \$14,488.27 IN INVESTIGATIVE COSTS; FOR A TOTAL OF \$41,258.86, WHICH SHALL BE INCREASED BY THE AMOUNT OF THE TRANSCRIPT COSTS FOR TODAY'S PROCEEDING.

THERE SHALL BE NO ATTORNEYS FEES IMPOSED IN ACCORD WITH THE MOTION OF RESPONDENT AND THE WITHDRAWAL OF THE REQUEST FOR SUCH FEES BY THE ATTORNEY GENERAL.

AN ORDER MORE FULLY ARTICULATING THE BOARD'S REASONING WILL FOLLOW, AND THE BOARD'S ORDER IS EFFECTIVE 30 DAYS FROM TODAY.

Respondent's counsel, Mr. Kern, moved for a stay pending a review by the Appellate Division.

The Board, upon motion made and seconded, voted to go into executive session for deliberations and advice of counsel. All parties, except counseling staff, left the room.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO UNANIMOUSLY DENY THE STAY PENDING A REVIEW BY THE APPELLATE DIVISION AS REQUESTED BY MR. KERN IN THE MATTER OF DR. DAITER.

**10:00 a.m. MEHTA, Lalitkumar H., M.D. (License #MA 40545)
(LEVINE, Debra W., Counseling D.A.G.)**

**FARBER, Zulima V., Esq. for Respondent
GARCIA, Alexandra, D.A.G. for Complainant**

This matter was heard before a Committee of the Board. The Committee made a recommendation to the Board and the Board would be asked to accept, modify or reject that recommendation.

Enclosed was D.A.G. Garcia's February 20, 2004 letter brief to the Board of Medical Examiners was submitted in support of the Attorney General's emergent application for an immediate temporary suspension of the license of Respondent Lalitkumar H. Mehta, M. D. to practice medicine in the State of New Jersey. The Attorney General's application was premised upon Counts One and two of the Verified Complaint, the Exhibits thereto, Order to Show Cause, and the Certification of Counsel. Also enclosed is Respondent's Answer to Verified Complaint filed on March 3, 2004.

THE BOARD UPON MOTION MADE AND SECONDED, VOTED TO DELEGATE TO THE COMMITTEE OF THE BOARD IN ACCORDANCE WITH THE AUTHORITY VESTED IN N.J.S.A. 45:1-22 TO HEAR THE APPLICATION BROUGHT BY THE ATTORNEY GENERAL FOR THE TEMPORARY SUSPENSION OF THE LICENSE OF DR. MEHTA AND SHOULD THIS COMMITTEE FIND CAUSE TO DO SO, TO ORDER THAT A TEMPORARY SUSPENSION OF LICENSURE BE ENTERED OR THAT OTHER AUTHORIZED ACTIONS OR LIMITATIONS BE IMPOSED, AND ORDER MADE BY THE COMMITTEE

SHALL BE EFFECTIVE IMMEDIATELY UPON PRONOUNCEMENT AND SHALL HAVE THE FULL FORCE AND EFFECT AS AN ORDER OF THE FULL BOARD. FOLLOWING THE HEARING, THE COMMITTEE SHALL PREPARE A WRITTEN ORDER DETAILING THE FINDINGS MADE BY THE COMMITTEE WHICH ORDER SHALL BE PRESENTED TO THE FULL BOARD AND THE FULL BOARD MAY ADOPT, MODIFY, OR REJECT THE ORDER OF THAT HEARING COMMITTEE.

**11:30 a.m. PRINTZ, Bruce I., D.O. (License # MB 40791)
(FLANZMAN, Steven N., Counseling D.A.G.)**

SURGENT, Jay, Esq. for Respondent
MATTHEWS, Megan K., D.A.G. for Complainant

This matter was heard before a Committee of the Board. The Committee would make a recommendation to the Board and the Board would be asked to accept, modify or reject that recommendation.

Enclosed was D.A.G. Matthews February 24, 2004 letter brief submitted to the Board of Medical Examiners was submitted in support of the Attorney General's emergent application for an immediate temporary suspension of the license of Respondent, Bruce Printz, D.O. to practice medicine and surgery in the State of New Jersey. The Attorney General's application was premised upon the Verified Complaint, the exhibits thereto, Order to Show Cause and Certification of Counsel.

THE BOARD UPON MOTION MADE AND SECONDED, VOTED TO DELEGATE TO THE COMMITTEE OF THE BOARD IN ACCORDANCE WITH THE AUTHORITY VESTED IN N.J.S.A. 45:1-22 TO HEAR THE APPLICATION BROUGHT BY THE ATTORNEY GENERAL FOR THE TEMPORARY SUSPENSION OF THE LICENSE OF DR. PRINTZ AND SHOULD THIS COMMITTEE FIND CAUSE TO DO SO, TO ORDER THAT A TEMPORARY SUSPENSION OF LICENSURE BE ENTERED OR THAT OTHER AUTHORIZED ACTIONS OR LIMITATIONS BE IMPOSED, AND ORDER MADE BY THE COMMITTEE SHALL BE EFFECTIVE IMMEDIATELY UPON PRONOUNCEMENT AND SHALL HAVE THE FULL FORCE AND EFFECT AS AN ORDER OF THE FULL BOARD. FOLLOWING THE HEARING, THE COMMITTEE SHALL PREPARE A WRITTEN ORDER DETAILING THE FINDINGS MADE BY THE COMMITTEE WHICH ORDER SHALL BE PRESENTED TO THE FULL BOARD AND THE FULL BOARD MAY ADOPT, MODIFY, OR REJECT THE ORDER OF THAT HEARING COMMITTEE

**1:00 p.m. ZAHL, Kenneth, M.D. (License #MA 56413)
(FLANZMAN, Steven N., Counseling D.A.G.)**

**JACKSON, John Zen, Esq., for Respondent
HAFNER, Doreen D.A.G. for Complainant**

Drs. Lucas & Perry were recused from discussion and vote in this matter and left the room.

Enclosed for Board consideration in the matter of Dr. Kenneth Zahl was D.A.G. Hafner's February 25, 2004 letter to the Board, copy of the Motion for Modification of the May 5, 2003 Order, along with Letter Brief, Certification of Counsel, and Exhibits, all dated February 25, 2004.

Also included for the Board's review were the May 5, 2003 Order; April and May, 2003 Board minutes in this matter. Attached was Respondent's counsel, Mr. Jackson's February 26, 2004 Notice of Motion to Modify the Order of May 5, 2003 and other Relief and Certification Regarding Facsimile Signature and D.A.G. Hafner's letter of Response to the Notice of Motion to Modify the Order of May 5, 2003 filed by counsel John Zen Jackson and letter brief to the Board.

The Board, upon motion made and seconded, voted to go into Executive Session for deliberations and advice of counsel. All parties, except counseling staff, left the room.

The Board returned to Open Session and announced the following motion:

THE BOARD UPON MOTION MADE AND SECONDED, VOTED TO ADJOURN THE ZAHL PROCEEDING AND MOVE IT TO A COMMITTEE OF THE BOARD FOR A WEEK FROM TODAY, MARCH 17, 2004. IT IS THE BOARD'S UNDERSTANDING THAT THE PARTIES HAVE AGREED THAT DR. ZAHL WILL PRACTICE IN THE INTERIM PERIOD WITHOUT A PRACTICE MONITOR REQUIRED BY THE BOARD'S ORDER, HOWEVER, DR. ZAHL SHALL NOT SUBMIT BILLS FOR MEDICAL PROCEDURES HE PERFORMS DURING THAT ONE WEEK PERIOD.

OLD BUSINESS

**1. HELLER, Elliot M., M.D. (License # MA 44554)
(FLANZMAN, Steven: Counseling D.A.G.)**

**POPLAR, Carl D., Esq., for Respondent
BEY, Hakima D.A.G. for Complainant**

The Board was asked to review the enclosed Report and Recommendation of Hearing Committee of Dr. Robins, Dr. Trayner and Mr. Weiss held October 30, 2003.

Enclosed was the evidence entered on October 30, 2003 P-1 through P-8 along with transcripts and the submission of Dr. Heller's Litigation Statement and Exhibits along with copy of the October 30, 2003 Preliminary Evaluation Committee Meeting transcript and other pertinent materials in this matter.

D.A.G. Bey requested the Board to adopt, reject or modify the Committee's Recommendation.

The Board, upon motion made and seconded, voted to go into executive session for deliberations and advice of counsel. All parties, except counseling staff, left the room.

THE BOARD UPON MOTION MADE AND SECONDED, VOTED TO MODIFY THE RECOMMENDATION OF THE COMMITTEE BASED ON THE BOARD'S CONSIDERATION OF THE EGREGIOUSNESS OF THE OFFENSES OF DR. HELLER. THE BOARD RECOMMENDS THAT THE PERIOD OF ACTIVE SUSPENSION RECOMMENDED BY THE COMMITTEE BE INCREASED FROM THE COMMITTEE'S RECOMMENDATION OF 2 MONTHS ACTIVE TO A PERIOD OF 60 MONTHS ACTIVE . THUS THE SUSPENSION WOULD RUN THROUGH NOVEMBER 8, 2007.

NEW BUSINESS

None.

The meeting ended at 7:45 p.m.

Respectfully Submitted,

Glenn Farrell Esq.,
Vice President
Chairperson for Open
Disciplinary Matters

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