

**Open Minutes
New Jersey State
Board of Medical Examiners
Disciplinary Matters Pending Conclusion**

June 12, 2002

A meeting of the New Jersey State Board of Medical Examiners was held on Wednesday, June 12, 2002 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 David M. Wallace, M.D., Chairperson for Open Disciplinary Matters.

PRESENT

Present were Board Members Chen, Criss, Farrell, Haddad, Harrer, Huston, Lucas, Moussa, Perry, Ricketti, Robins, Trayner, Wallace, Walsh and Weiss.

EXCUSED

Board Members Desmond, DiFerdinando, Patel and Rokosz.

ALSO PRESENT

Deputy Attorneys General Dick, Ehrenkrantz, Flanzman, Gelber, Kenny, Levine and Warhaftig; Executive Director Roeder and Medical Director Gluck, New Jersey State Board of Medical Examiners.

RATIFICATION OF MINUTES

The Minutes from the May 8, 2002 Board meeting were approved with clerical changes.

HEARINGS, PLEAS, RETURN DATES, APPEARANCES

**ALMAHAYNI, Rania, M.D. (Counseling Deputy: DICK)
WARHAFTIG, Jeri, D.A.G.**

(Proceedings recorded by Linda L. Mancuso-Psylos, C.S.R., GUY J. RENZI & ASSOCIATES)

Order to Show Cause and Verified Complaint filed March 8, 2002 seeking a temporary suspension of Dr. Almahayni's license to practice medicine and surgery in the State of New Jersey, based upon allegations that Respondent's continued licensure constitutes a clear and imminent danger to the public arising from her untreated delusional disorder. This matter was to be heard before the Board on March 13, 2002. Dr. Almahayni and Louis E. Baxter, Sr., M.D., FASAM, Executive Medical Director of the Physicians' Health Program, agreed to and signed a Consent Order of Voluntary Surrender that adjourned the hearing until the Board's April 10, 2002 meeting. Dr. Almahayni agreed to the voluntary surrender of her license until such time as this matter is decided by the Board. This matter was adjourned from the May 8, 2002 meeting until this meeting. Enclosed were the Order to Show Cause and Verified Complaint filed March 8, 2002 which included D.A.G. Warhaftig's Certification filed March 8, 2002 with Exhibits A through G (sealed by the Board at its March 13, 2002 meeting). Also, enclosed were the Consent Order of Voluntary Surrender signed by Dr. Almahayni on March 15, 2002; Dr. Almahayni's Answer with Exhibits A through C4 filed April 24, 2002; D.A.G. Warhaftig's May 3, 2002 letter to Dr. Almahayni confirming their conversation on May 3, 2002; and Dr. Almahayni's May 7, 2002 letter to the Board.

The hearing began by addressing the issue of sealing certain evidence in this matter. D.A.G. Warhaftig informed the Board that the State did not object to Dr. Almahayni's request that any evidence placed into the record during

the hearing remain sealed. Dr. Almahayni asked the Board to honor her request because many of the documents contain very sensitive and intimate information that could easily be misunderstood or mishandled by the public.

The Board voted to go into executive session. Deputies, other than counseling staff, left the room, along with all other members of the public present.

The Board returned to open session with all parties present and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO CONTINUE TO SEAL EXHIBITS A AND D ATTACHED TO THE ATTORNEY GENERAL'S CERTIFICATION IN THIS MATTER, EXCEPT TO THE EXTENT THEY MAY BE RELIED UPON BY THE BOARD IN ANY ORDER THAT MAY ISSUE. THE BALANCE OF THE MATERIALS SUBMITTED WITH THE ATTORNEY GENERAL'S CERTIFICATION AND DR. ALMAHAYNI'S SUBMISSION ARE NOT NORMALLY SEALED AND ARE OPEN TO PUBLIC INSPECTION BECAUSE MANY ARE ALREADY IN THE PUBLIC DOMAIN. THE BOARD VOTED TO REMOVE THE SEAL FROM THE OTHER DOCUMENTS ATTACHED TO THE CERTIFICATION AND WOULD NOT SEAL DR. ALMAHAYNI'S EXHIBITS. IN ADDITION TO THE DOCUMENTS NOT YET BEFORE THE BOARD, THE BOARD INFORMED DR. ALMAHAYNI THAT SHE COULD RENEW HER MOTION TO SEAL DOCUMENTS AS THEY WERE INTRODUCED INTO EVIDENCE.

D.A.G. Warhaftig reminded the Board that the hearing concerned the Attorney General's application for the temporary suspension of the medical license of Dr. Almahayni. The Attorney General sought the temporary suspension based upon its determination that the doctor's practice constituted a clear and imminent danger to the public, relying primarily on the papers before the Board, particularly the Complaint and Certification. The Attorney General's Office was advised of this issue by the Physicians' Health Program.

Prior to the hearing, Dr. Almahayni and the Attorney General's Office had stipulated that certain evidence could be admitted. For ease of identification, D.A.G. Warhaftig pre-marked the following: The first item attached to the State's Certification filed March 8, 2002 which was Exhibit A was marked for identification as S-1; Exhibit B was marked as S-2; Exhibit D was marked as S-4 for identification and was also sealed by the Board as result of Board's ruling; Exhibit E was marked for identification as S-5; Exhibit F was marked for identification as S-6; and Exhibit G was marked for identification as S-7. In addition to those items, the parties also stipulated to the admissibility S-8 (also sealed) which is a certification of Dr. Fernandez which supplements the report already sealed by the Board. Additionally, the parties have stipulated to the admissibility of R-1 which was Dr. Almahayni's certified statement of April 18, 2002 provided by Dr. Almahayni; R-2, Dr. Almahayni's exhibit A; R-3, Dr. Almahayni exhibit B; R-4 Dr. Almahayni's exhibit C and Dr. Almahayni's subsequent letter to the Board dated May 7, 2002 was marked as R-5. Also, R-6 and R-7, which were Dr. Almahayni's performance evaluations from Barnes and Noble, were admitted and handed out to the Board members.

D.A.G. Warhaftig began her argument by reminding the Board that this matter was reported to the Board by the Physicians' Health Program (the "PHP"). The PHP received from the Board of Internal Medicine two items of correspondence which have already been marked and admitted into evidence. As a result of the Board of Internal Medicine's review of those letters, the Board of Internal Medicine contacted the PHP which, in turn, contacted the Board. In cooperation with the PHP, Dr. Almahayni submitted to a psychiatric evaluation. Dr. Fernandez', after he performed a psychiatric evaluation, concluded that Dr. Almahayni suffered from a delusional disorder and as a result of her delusional state which remains untreated, that she is not competent to practice medicine. The reports were in evidence and contained in S-4. Subsequent to the filing of the Order to Show Cause and Complaint, Dr. Almahayni voluntarily agreed to not practice. Since her March 21, 2002 voluntary surrender, additional events took place which were before the Board as S-8. On or about March 11, Dr. Fernandez became aware that Dr. Almahayni was taken to Helene Fuld Crisis Center by police because Doctors Baxter and Fernandez developed the opinion that Dr. Almahayni was dangerous to Dr. Fernandez. Dr. Almahayni is not practicing medicine, but has been employed on a full time basis at Barnes & Noble since the Spring of 2000. The letters to Internal Medicine, the submissions to this Board of certified statements, and the reports of Drs. Fernandez and Baxter demonstrate an active delusional disorder which remains untreated, and it was the Attorney

General's position that the doctor is not competent to practice medicine and surgery in the State of New Jersey.

Dr. Almahayni was sworn. She began by denying the claim that she was delusional and claimed that she was a woman in pain because she suffers from abuse syndrome. According to the doctor, she has been abused by people and governments for a number of years and this abuse has resulted in excruciating pain. For years she has been under the care of a psychiatrist and even during those times when there was no insurance or money, she went to the clinic for help. Continually, in spite of her efforts for help, the mental health practitioners insisted that they could not help her. She was desperate and because no one would heed her warnings about the killings and homicides that were taking place, she wrote the letters to the Board of Internal Medicine. According to Dr. Almahayni, she sent the letters thinking that she was asking for their help.

Addressing the issue of Dr. Fernandez' report, Dr. Almahayni believed that he was the one that was disturbed, not she. According to her, the psychiatric report was fabricated and it was she that was threatened by him, not vice versa. She believed that he was involved in her abuse and in terrorism. She asked the Board to consider that if she were delusional, how is it that she has been working in customer service at the bookstore and continually received excellent performance evaluations. Finally, she asked the Board to consider the evaluations from her current physician under whose care she has been for the last couple of months.

D.A.G. Warhaftig questioned the doctor as to her reasoning for copying one of her letters (R-1) to the Commissioner/President of Syria, Arab Republic. Dr. Almahayni explained that the letter was submitted to the highest official because she was being attacked by the Clintons. This attack had been going on for years and she attempted to contact other agencies, however, her pleas had fallen on deaf ears. She had hoped that by sending letters to the highest officials that some action would be taken.

When questioned on Exhibit R-5, which is the report from a psychiatrist, Dr. Ramsay, Dr. Almahayni believed that he practices appropriately. She believed, however, that many of the other psychiatrists were confused. She admitted that she has a problem dealing with psychiatrists and believed that twelve out of the thirteen she has seen are/have been criminals. Prior to March of 2002, she had taken Risalol, but at a low dose. Currently she takes Zyprexa, 10mg.

Dr. Almahayni testified she became Board eligible in 1993 and has attempted to take the examination five times. Each time she attempted to take the test, her brain would cease functioning. She has gotten better each time, finishing more of the questions, however, she gets frightened every time she attempts to take the test. In part, according to Dr. Almahayni, this is because the Clintons are threatening her and the abuse is crippling. One of the other reasons that she copied the president of Syria and the White House on her correspondence is because she received a letter from the White House that assured her that they would investigate her complaints. However, she found the White House, in particular the Clintons, to be very abusive and assaulting. Since the new government has come into office, it has been much better. She also clarified for the Board when questioned further that she has not been diagnosed with abuse syndrome by a medical doctor, but this is the diagnosis offered by her lawyer.

Dr. Almahayni summed up by asking the Board to believe that she is not delusional or a danger to the public. She is a woman abused severely by family, friends, governments, and the Clintons. She is under psychiatric care to help cope with what she is going through. In particular, she asked the Board to take into consideration her performance evaluations from the bookstore as these offered the most correct picture of her mental health at this time. She emphasized that since 1991, the date of her initial licensure, she has not misused or abused her medical license. Finally, she asked the Board to consider that she is not a danger and wished that she could have provided a letter from her current psychiatrist to that effect.

In conclusion, D.A.G. Warhaftig urged the Board to conclude that the record before it was clear. The doctor has been diagnosed with delusional disorder, a condition supported by the other evidence admitted into evidence. Although the doctor may be in active therapy at this time, there is no evidence that she is currently competent to practice medicine. To the contrary, Drs. Fernandez and Baxter believe that she is not competent. The danger to the public is not just whether she might or might not engage in violent acts, the danger to the public is the lack of credible evidence that she is competent to practice. D.A.G. Warhaftig requested that the Board take the necessary

steps to continue the doctor's suspension until such time as there may be a trial in the matter.

The Board noted for the record that Dr. Fernandez' report with attachments, which is S-8, also would be sealed.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO ADMIT THE STIPULATED EVIDENCE S-1, S-2, S-4, S-5, S-7, R-1, R-2, R-3, R-4 AND R-5. WITH REGARD TO S-8, R-6, R-7, AND DR. FERNANDEZ' CERTIFICATION, THE BOARD VOTED TO SEAL THOSE DOCUMENTS, EXCEPT TO THE EXTENT THOSE MAY BE RELIED UPON BY THE BOARD IN ANY ORDER THAT MAY ISSUE, THEY WILL BECOME PART OF THE PUBLIC RECORD.

It was noted that D.A.G. Warhaftig skipped S-3. Therefore, S-3 was entered into evidence with the consent of Dr. Almahayni.

The Board voted to go into executive session. Deputies, other than counseling staff, left the room, along with all other members of the public present.

The Board returned to open session with all parties present and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO TEMPORARILY SUSPEND THE LICENSE OF DR. ALMAHAYNI BASED UPON HER APPEARANCE AND THE MATERIALS IN HER LETTERS WHICH CONFIRM THE ISSUES RAISED IN THE MATERIALS SUBMITTED BY THE ATTORNEY GENERAL. THE BOARD ALSO EXERCISED ITS OWN EXPERTISE IN THE MATERIALS SUBMITTED AND IN ANALYZING THE LETTERS DR. ALMAHAYNI WROTE WHICH CORROBORATE A FINDING THAT HOWEVER SINCERELY SHE BELIEVES HER CLAIMS OF BEING ABUSED AND RECEIVING TERRORISTIC THREATS, SHE IS SUFFERING FROM A DELUSIONAL DISORDER, AND THE BOARD HAS NO ALTERNATIVE BUT TO SUSPEND PENDING A PLENARY HEARING IN THIS MATTER. THE BOARD WILL NOT CONSIDER ANY REAPPLICATION TO LIFT THE SUSPENSION UNTIL DR. ALMAHAYNI RECEIVES PSYCHIATRIC TREATMENT AND THE BOARD RECEIVES ASSURANCE THAT SHE IS ABLE TO PROPERLY DISCHARGE THE RESPONSIBILITIES AS A PHYSICIAN AND DEMONSTRATE COMPETENCE TO PRACTICE. THE TEMPORARY SUSPENSION IS EFFECTIVE IMMEDIATELY ON ANNOUNCEMENT ORALLY ON THE RECORD. A WRITTEN ORDER WILL FOLLOW.

GRASSO, Armand J., M.D. (Counseling Deputy: LEVINE)
GORRELL, Joseph M., Esq., for Respondent
WARHAFTIG, Jeri, D.A.G., for Complainant

(Proceedings recorded by Linda L. Mancuso-Psyllos, C.S.R., GUY J. RENZI & ASSOCIATES)

This matter was set down for hearing in the matter of Armand Grasso, M.D. Enclosed for Board review was the April 18, 2002 Initial Decision of Administrative Law Judge Maria Mancini La Fiandra. This matter was initiated based upon a Complaint filed April 17, 2000 alleging gross malpractice, negligence, incompetence; repeated acts of same; professional misconduct; and employment of deception, misrepresentation, and false pretense. Enclosed were the Administrative Complaint filed April 17, 2000; Answer to Administrative Complaint filed April 25, 2000; Exceptions to the Initial Decision on behalf of Dr. Armand J. Grasso, M.D., filed May 10, 2002; the Attorney General's Exceptions filed May 13, 2002 with attachments; the Attorney General's May 17, 2002 letter brief with Exhibits A and B in reply to Respondent's Exceptions and as a supplement to the Attorney General's Exceptions; and Respondent's Letter Brief with attachment filed May 21, 2002 offered in response to the Exceptions filed by the Attorney General. Also, enclosed was D.A.G. Warhaftig's Certification filed May 29, 2002 in support of the State's Application for Costs. In the event that the Board adopts all or part of ALJ La Fiandra's Initial Decision, the Attorney General's Office asked that this Certification be considered by the Board when penalty is determined.

In addition, enclosed was Mr. Gorrell's May 23, 2002 letter to Executive Director Roeder requesting one hour for oral argument on exceptions (rather than 20 minutes) and advising that should a mitigation hearing be necessary,

he is prepared to present approximately six witnesses on behalf of Dr. Grasso in that proceeding. Also enclosed was D.A.G. Kenny's May 30, 2002 response, on behalf of Deputy Attorney General Warhaftig in her absence, and Executive Director Roeder's May 31, 2002 letter advising the parties of Board President Harrer's decision on this matter. It was noted that there is no legal requirement for oral argument on exceptions to an Initial Decision from an ALJ, and that this matter has been extensively briefed. However, Board President Harrer provisionally determined, subject to Board ratification at this meeting, to grant to each party an additional 10 minutes for oral argument on exceptions. Therefore, the parties will each have 30 minutes, rather than 20 minutes, for oral argument on exceptions, subject to Board approval. Dr. Harrer also provisionally ruled that both parties were to identify by June 5th the witnesses they intended to produce and provide a brief proffer as to their testimony. Dr. Harrer further advised the parties that to the extent the testimony is cumulative, irrelevant or non-probative, it will be disallowed.

Dr. Robins announced his recusal from this matter and left the table.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE DR. HARRER'S DECISION TO PERMIT EACH PARTY AN ADDITIONAL 10 MINUTES FOR ORAL ARGUMENT TOTALING 30 MINUTES.

Mr. Gorrell began by reading a portion of the transcript of the hearing because he believed that it served as a prime example of the fundamental flaws in the Judge's decision. By way of example, while Dr. Grasso was on call in 1995 at Saint Joseph's Hospital and Dr. Zhuravleva assisted at a delivery, the issue was whether Dr. Grasso timely responded to information given by the residents. When the witnesses were questioned during the trial, no one could accurately recall what was told to Dr. Grasso, what findings were communicated to him, or how many times he had been called. In fact, the Judge even asked whether a witness could recall anything about the conversation at all and the witness answered no. Yet, in spite of this testimony, the Judge found it undisputed that Dr. Zhuravleva told Dr. Grasso that the patient had presented with a footling breach. Mr. Gorrell argued that it was incomprehensible for the Judge to make that finding in light of the testimony received at trial.

He then went on to argue the issue of when a baby reaches pulmonary maturity. The State's witness, Dr. Strunk, opined that a fetus generally does not achieve fetal pulmonary maturity until 39 weeks. This was based, according to Dr. Strunk, on text books. Yet, when one examines the text books, it clearly states that it is at 37 weeks. Although it was harmless error in this matter because ultimately the Judge determined that the discrepancy between the two experts did not matter, nonetheless, the State's expert made a fundamental error. In spite of the error, the Judge relied heavily on Dr. Strunk's opinion.

Mr. Gorrell addressed the L.S. case, which, as he pointed out occurred almost fourteen years ago. He did not believe that served any public interest to prosecute Dr. Grasso for something that happened in 1986. Summarizing the case, the Board was told that the patient had undergone a number of surgeries, gave her medical history and complained of abdominal pain. Dr. Grasso treated her and she returned about six months later still complaining of the pain. In April 1987, the doctor performed a cystectomy. In the course of that procedure, it became necessary to remove a 2-cm portion of the fallopian tube. He did not describe it and put the procedure in the record as a tuboplasty. Mr. Gorrell argued that nowhere in the Complaint is there a charge of improper documentation by Dr. Grasso in that case, a case which occurred fourteen years ago. He stated the Judge found nothing wrong with the procedure performed by Dr. Grasso and found the consent he obtained was appropriate. He posited the question concerning what findings the Judge made against Dr. Grasso. He stated the Judge found that first, Dr. Grasso wrongly advised the husband to go for semen analysis and secondly, that he forgot to tell the patient he removed a portion of the fallopian tube. In May 1989, according to the patient, the doctor discussed the issue of whether or not she could get pregnant. The Judge determined that having the husband tested for semen levels was deceptive, but she did not explain why. Mr. Gorrell stated when one reviews Exhibit S-13, the operative report from Dr. Safier, which was performed a year after Dr. Grasso performed surgery and three months after Dr. Grasso had discussed potential pregnancies, it is clear that the husband was sent for semen tests before as well as after the surgery. Thus, one could conclude that in May 1989 it is clear it was not established this patient had a non-functioning fallopian tube, and even if it was, sending the husband was correct because the couple could have explored in vitro fertilization. Both experts testified that it is within the standard of practice to test a husband's

semen even if the tube was not functioning, even though in this case that was not established. Mr. Gorrell urged the Board to conclude that there was nothing unusual or deceptive in what Dr. Grasso did. Rather, Mr. Gorrell posited, it was a fundamental misunderstanding by the Judge who believed that the removal of a portion of the tube made the tube non-functioning, even though it was not established at the time. Regarding not telling the patient about the removal of a piece of the fallopian tube after surgery, Mr. Gorrell argued that it was conjecture to conclude what happened in conversation thirteen years ago. Nonetheless, the Judge found that the doctor was deceptive in purposely not informing the patient about what had occurred during the surgical procedure. During the trial, it would have been easy for Dr. Grasso to get up and "say sure I did it." Instead, he readily admitted he did not remember what occurred in the conversation at the time. The tube was not determined to be nonfunctional. The Judge did not understand that. If anything, if Dr. Grasso had told her about the removal of the piece of the tube, it would be more likely that they would have discussed how she could get pregnant. It was more likely that he did discuss that subject with her. In 1991, this patient returned to Dr. Grasso for an examination. When asked why, she said "I trusted him." For the particulars, Mr. Gorrell referred the Board to the exceptions he filed for a more detailed analysis of these issues. Addressing the second case, the delivery with forceps where the baby suffered paralysis from a spinal cord injury, Mr. Gorrell maintained that there was not sufficient proof that Dr. Grasso caused the injury. Even the State's expert, Dr. Strunk, was not able to explain how the injury occurred, except to opine that it must have occurred through excessive force. But later, he changed his mind. The Judge found that it must have been because of excessive force based purportedly on the testimony of the nurse and anesthesia doctors who alleged that the delivery was strained --- a constant pulling downward. But, also in evidence is the testimony that Dr. Grasso only used "force" with the forceps during the contractions, which is the standard of practice. Dr. Grasso could not recall whether he used fundal pressure. There was no testimony as to the standard of the proper amount of force. Yet, the Respondent's expert, Dr. Frederick Perl, explained that the fact that the baby suffered a cephalohematoma and did not demonstrate misapplication of the forceps. Dr. Perl opined that the injury more than likely was caused by the baby traveling through the birth canal. The Judge disregarded Dr. Perl because he did not explain the forceps mark. Mr. Gorrell argued Dr. Perl did not explain the forceps mark because no one asked and it is not unusual. He argued forceps marks occur, and it does not mean anything was done wrong. Is it possible Dr. Grasso caused the injury? Mr. Gorrell answered "yes." Was there demonstrable proof that he caused the injury? Mr. Gorrell answered "no." He referred the Board to the expert reports because he maintained that the Board would determine that Dr. Strunk waffled on his own opinion.

The A.B. case, according to Mr. Gorrell, occurred in 1995, seven years ago. At the time, Dr. Grasso was the on-call physician. According to the testimony, he was telephoned by the delivery nurse, Diane Mayo, who informed him that a woman was in labor (breech) and that the residents would be delivering the child vaginally. The resident believes he told Dr. Grasso that she was 8 cm dilated. The Judge, in spite of the contradictory testimony as to what was conveyed to Dr. Grasso, found that he negligently failed to answer the call.

Finally, Mr. Gorrell argued that because of the age of these cases, Dr. Grasso has been prejudiced because to defend himself he had to rely on the witnesses' faded memories. Witnesses could not remember and the doctor could not remember. It is patently wrong and violates the concept of laches.

D.A.G. Warhaftig began by referring the Board to the papers submitted by the State for a complete briefing on the issues. However, she briefly explained some of the more salient points of the State's position. Concerning Mr. Gorrell's argument that the footling breech was not a material matter since the birth was normal, what Mr. Gorrell failed to inform the Board was about Dr. Grasso's obligation to evaluate the patient. His failure to abide by a basic standard of practice was incomprehensible.

D.A.G. Warhaftig acknowledged that Mr. Gorrell would naturally have issues with the State's expert because he disagreed with Dr. Perl, the respondent's expert. In particular, the disagreement centered over the timing of the fetal maturity dates. But that is a nonissue, a red herring if you will, because Respondent prevailed on that issue. However, Mr. Gorrell is asking the Board to discount all of Dr. Strunk's testimony because of this disagreement; in essence, to discount all of his testimony because of it. The Judge heard the testimony of the experts and relied on Dr. Strunk's testimony in most areas. She reminded the Board that experts will for the most part disagree, but that is not a basis for discounting expert testimony totally. Regarding L.S., Mr. Gorrell told the Board that the doctor removed a 2 cm portion of her tube. Mr. Gorrell also acknowledged that Dr. Grasso did not inform the

patient. D.A.G. Warhaftig directed the Board to the pathology report in which it stated he performed a "tuboplasty." This entry in the record is misleading. Dr. Grasso did not discuss the removal with anyone, in fact, the patient recalled and testified at trial, that Dr. Grasso told her that everything was fine. Then to compound the deception, Dr. Grasso had her husband sent for a semen analysis in spite of the fact that Dr. Grasso knew that she could not conceive.

Concerning the AI matter, the State raised the question whether there was proof that the doctor caused the injuries. She reminded the Board that the Attorney General only has to prove risk of harm. In reviewing the Board, she urged the Board to conclude that the State has met the burden of proof. Turning the Board's attention to the JL case, the evidence demonstrated that there were marks on the head which indicated a rotated application of the forceps. In that case Dr. Perl did not have an explanation and that is when Judge rightfully relied on Dr. Strunk's testimony. Regarding A.B. and the issues Mr. Gorrell raised, the record is clear that at 5:30 in the evening Dr. Grasso was told the patient arrived and that he was contacted again at 5:40. S-21 in evidence is Dr. Grasso's letter to Sister Jane which specifically lists those times. The baby was delivered at 6:14. When he finally went to evaluate the patient, the baby was already delivered. Thirty-four minutes passed between the first call and the doctor's response. The only expert in this count was the State's expert and he testified that this seriously deviated from the appropriate standard of care when he failed to respond and assess that patient in a timely manner. Finally, Mr. Gorrell raised a question of laches and he asks the Board to recognize the purpose of the doctrine is the obligation to a party to come forward and defend himself in a timely fashion, but in this instance according to the Deputy, there is no undue prejudice or unfairness to Dr. Grasso. The Doctor had all of his records, the hospital records were available, the materials were reviewed by experts, and testimony was obtained from all interested parties. There is no prejudice to Respondent from this Board and should the Board fail to consider this matter, it would jeopardize the safety and welfare of the citizens of this State.

What's this case about? She urged the Board to concentrate on two things: grossly negligent conduct which in some instances harmed patients and deception and misrepresentations of a licensee to his patients. When Dr. Grasso operated on LS in 1988, he betrayed her trust when called that procedure a tuboplasty. He never told her what he actually removed. He wrote a false operative report. Later when Dr. Safier was performing the test because the records did not accurately reflect what had occurred, he did not understand the patient's true medical condition. Dr. Grasso continued to treat L.S. having told her and her husband that the surgery went well. Then, he went and sent RS for semen analysis. Here was a young couple who wanted to get pregnant, and they both knew that she only had one fallopian tube, but in the absence of full knowledge of the surgery. The Judge had no choice by to conclude that Dr. Grasso had engaged in acts she found deceptive and thus, that Dr. Grasso had engaged in professional misconduct.

Turning the Board's attention to the case of A.L's delivery, she summarized the care provided. The patient was admitted to Pascack Valley Hospital and according to S-26 and S-27, the delivery was so unusual that Nurse Kelly wrote personal notes. When AL was delivered, she was in the face up position. Dr. Grasso used forceps in the delivery and according to the evidence, he both misapplied and misused forceps which was gross negligence. There was testimony from observers in the room that the doctor's shoulders and arm could be seen shaking and that he was sweating. Although the doctor denied any strain or pulling hard in a downward direction, Nurse Kelly said the force from Dr. Grasso was unlike anything she had ever seen. He was exhausted. Neither expert described the forceps procedures to properly include excessive force or downward pulling as all the witnesses testified had occurred. In addition to downward force, there were marks on the baby's head. Judge found misplacement of the forceps either parallel to the floor or rotated concluding that the child was severely injured, resulting in total paralysis. Dr. Strunk testified that if the forceps were rotated, but misapplied on the head, that would be a third element together with the force that placed the baby at risk of harm for cervical injury, the exact injury she suffered. It is not the State's burden to prove the actual harm. The State proved risk of harm. It is a risk of harm to other babies who will be or have been delivered by Dr. Grasso.

D.A.G. Warhaftig also argued that in the matter of AB the record is clear that Dr. Grasso failed to respond for thirty-four minutes. This baby was delivered by emergency by another resident. Dr. Grasso presented no expert defense on this point. Mr. Gorrell would have this Board believe that Dr. Grasso made a mistake when he filled out his renewal application in 1997. If it was a mistake, Dr. Grasso never offered any evidence at trial to support

this "mistake," instead he confirmed it was his signature and that he signed the reapplication claiming that the answers to the questions were true. He answered that no malpractice payments were made on his behalf, yet in fact there had been one. When Dr. Grasso appeared, before the Preliminary Evaluation Committee, he was asked about his status of hospital privileges. In 1999, he testified under oath that no limitations had been placed on his hospital privileges, when in fact, in September 1994, his privileges as an attending had been summarily suspended. That testimony was a lie and ALJ found that the doctor's testimony and his demonstrated actions taken as a whole constituted deception and misrepresentation. When one also looks at the explanations he has offered at the PEC, the Panel, Meadowlands Hospital, and during trial, the Board must conclude that there has been a pattern of deception and misrepresentation.

In summation, D.A.G. Warhaftig argued that the Judge heard eight days of testimony and had the opportunity to weigh the evidence against the credibility of the witnesses. The exceptions filed by Dr. Grasso are no more than red herring. The Attorney General urged the Board to adopt the Judge's findings of fact and conclusions of law. It is undisputed from the record that Dr. Grasso engaged in multiple acts of negligence and deception. He has placed his patients at risk of harm and will continue to do so, unless the Board stops him now.

Mr. Gorrell responded to D.A.G. Warhaftig's argument that the Respondent is only raising issues that in reality are nothing more than a red herring. He asked the Board to look at the record in the case. He posited that while the Judge found that fundamental facts were not disputed, to the contrary, the record is full of disputed facts. For example, the evidence demonstrated that when an investigation was done by Dr. Beaughard, the Department Chairman, which was dated April 18, 1995 when the procedure was done, he concluded that the patient was admitted approximately at 5:45, and the first call went to Dr. Grasso somewhere between 5:50 to 5:55. The time of delivery was established by Dr. Nichols at approximately 6:14. When one does the math, it does not add up to the thirty-five or more minutes which the Judge concluded transpired between the first call and Dr. Grasso's response. Similarly, the description of the surgery performed was accurate. It was not written to deceive the patient. He asked the Board to consider that if Dr. Grasso was trying to deceive, he would have written a more extensive surgery description or for that matter, an even less descriptive one. Instead, he wrote what was performed. Finally, regarding the laches argument, he asked the Board to take into consideration the fact that the Board knew about the first case in 1994. To have waited almost six years to prosecute is on its face contrary to the doctrine.

D.A.G. Warhaftig referred the Board to the State's submission and urged the Board to accept the findings of fact and conclusions of law of the ALJ for all the reasons previously proffered by the State.

The Board voted to go into executive session. Deputies, other than counseling staff, left the room, along with all other members of the public present.

The Board returned to open session, with all parties present, and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO ADOPT THE FINDINGS OF FACT AND CONCLUSIONS OF LAW OF ALJ LAFIANDRA IN THEIR ENTIRETY.

Mr. Gorrell requested that the Board members be polled as to which of the Board Members have reviewed the transcripts and exhibits in this case. D.A.G. Warhaftig objected to the request since there is no requirement that the Board demonstrate on the record to the satisfaction of Counsel that they have fulfilled their obligation in this case.

The Board voted to go into executive session for advice of counsel. Deputies, other than counseling staff, left the room, along with all other members of the public present.

The Board returned to open session, with all parties present, and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, STATED THAT IT HAS NO OBLIGATION TO BE POLLED BY A PARTY IN THE MANNER THAT MR. GORRELL HAS REQUESTED. HOWEVER, THE BOARD REPRESENTS THAT THE BOARD MEMBERS HAVE FULFILLED THEIR STATUTORY AND

REGULATORY OBLIGATIONS IN REVIEWING THIS MATTER.

The Board then proceeded to the mitigation, however, preliminarily D.A.G. Warhaftig requested clarification of the witnesses who would be presented. She had been informed that there would be five witnesses, including Dr. Grasso. Mr. Gorrell informed that Board that in addition to Dr. Grasso, Drs. Grazziano, DiBello, Thompson and Kierce would be presented. The State objected to two witnesses: Dr. Kierce, because he was a fact witness and offered character testimony at the hearing in this matter and that testimony is already before the Board, and second, regarding Dr. Grazziano and Dr. DiBello, both are testifying with regard to the time frame of Meadowlands Hospital 1996 to present. If they are both testifying, the Attorney General objected and requested that one or the other provide the character testimony, not both. Mr. Gorrell responded that the State's objection was premature because nothing indicates that the testimony will be duplicative. Moreover, he continued, if the Board is considering any active suspension, it should hear all information concerning the span of Dr. Grasso's practice in mitigation.

Mr. Farrell announced the Board's decision. The Board will consider all testimony and in the event the testimony is duplicative, the Board will limit it at that time and assess the credibility of each witness as it considers the penalty.

After Dr. Grasso was sworn, he read into the record a prepared statement. In short, he stated that he considers himself a physician who prides himself in adhering to and maintaining moral standards. During his years in both private practice and within a group practice, he believed he always provided his patients with the best quality of care. Six years into his practice, he found himself experiencing personal problems. It was devastating. Fortunately, he continued, St. Joseph's offered him a position and he is forever indebted to Sister Jane for giving him the opportunity. Tension developed between him and the Director of the Department, Dr. Beaughard, who was less than sympathetic toward his personal problems. Finally, Dr. Beaughard advised him of his inappropriate behavior at the hospital. The issue was dealt with solely in the hospital. He believed that the matter was done in strict confidentiality and handled at the hospital level. Dr. Grasso acknowledged that he was wrong in not telling the Board and apologized for the error he made when completing his two-year renewal application. He honestly failed to report a malpractice settlement. He assured the Board that he never intended to mislead the Board.

After this incident, he was fortunate to move into office space with Dr. James Thompson, who has always been a mentor and a true friend. He was unable to open a practice in Kearney. He informed the Board that he was a thriving practice and has the highest respect between medical community and patients he serves. He asked the Board to judge him for what he is today. Over the past ten years he has grown and now recognizes the highest quality of standards both in his personal and professional life. He thanked his family and colleagues for their support over the years. He concluded by expressing his deepest regrets to the Members of the Board.

No questions were posed from D.A.G. Warhaftig.

Dr. Roger Patrick Keirce was sworn and the Board learned that he is employed by St. Joseph's as Chairman of the Department, Director for Obstetric Gynecology since January 1996. He then gave the Board the benefit of his educational background and training. One of the duties he has as the Chairman of the Department is the responsibility regarding quality assurance. He has known Dr. Grasso since 1985, when he joined the group. He was his wife's obstetrician when she was pregnant and also has referred his sister-in-law to him. In preparing for his testimony today, he reviewed Dr. Grasso's records at the hospital from 1996 and he concluded that there have not been any complications, quality of care issues, or complaints from the staff concerning Dr. Grasso. In Dr. Kierce's opinion, Dr. Grasso is honest, forthright, pleasant to deal with, has excellent medical skills, has always taken care of his family, and Dr. Kierce has the highest regard for him. Regarding the claim of deception, Dr. Kierce testified that he has never found any instance personally or professionally to support such a claim.

D.A.G. Warhaftig sought clarification of Dr. Kierce's testimony that there have not been any complaints since 1996. Dr. Kierce affirmed that statement, but acknowledged that he had not reviewed the material of patient AB because she was treated in 1995 at Pascack Valley Hospital.

Dr. Louis J. DiBella, Jr. was sworn and questioned by Mr. Gorrell. Dr. DiBella has been licensed to practice

medicine and surgery in New Jersey since 1973, after he graduated in 1972 from the New Jersey College of Medicine. He established a solo practice after he was licensed. Subsequently, he entered into a partnership and continues to practice in it. He is Board certified and since 1980 has been on staff at Meadowlands Hospital serving as the Chief of Urology, Director of Surgery, and Co-Vice President of Medical Affairs. He was the Co-Chairman of the Board from 1986 to 1990 on the Board of Trustees at the Hospital. Presently, his responsibilities include Director and Vice President of Medical Affairs, quality assurance. Since Dr. Grasso joined the staff in 1998, Dr. DiBella was not aware of any complaints, investigations, or inquiries on Dr. Grasso. While Dr. DiBella does not work directly with Dr. Grasso, in order to prepare for his testimony, he performed his own "investigation" by inquiring with the staff, reviewing files, and talking to his colleagues. In essence, he learned that Dr. Grasso is a man of integrity, compassion, and exhibits the highest quality of moral standards. If there were any questions about his quality of performance, the issue would be referred to Dr. DiBella and since he has held this position, no referrals or complaints have been made against Dr. Grasso.

Dr. DiBella was questioned by D.A.G. Warhaftig wherein he acknowledged that he reviewed Dr. Grasso's physician referral file. This file would have contained any quality issues that might have arisen. He further testified that he did not look at Dr. Grasso's application for privileges, since that was outside the scope of his responsibilities. Dr. DiBella also confirmed that he was not aware of any issue prior to Dr. Grasso being granted privileges at his hospital or of any malpractice cases that may have been brought against Dr. Grasso prior to 1996.

The fourth witness, Dr. Eugene M. Grazziano, was sworn and questioned by Mr. Gorrell. The Board learned that he is licensed to practice medicine and surgery in Obstetrics and Gynecology and he provided the Board with his education and background. He has been practicing thirty-eight years. As Dr. Grazziano recalled, a colleague -- Dr. Thompson -- notified him that Dr. Grasso wanted to work in Hudson County sometime in 1996. Dr. Thompson told him that Dr. Grasso had previous problems and some medical problems that he had been working on with Dr. Canavan. Dr. Thompson was not more specific, so Dr. Grazziano testified that he contacted Dr. Canavan, who did not provide any specifics either. Dr. Grazziano recalled that he posed the question to Dr. Canavan whether he himself would work with Dr. Grasso. Dr. Grazziano recalled that Dr. Canavan responded with a resounding response of "Absolutely." Dr. Grazziano decided to hire Dr. Grasso. Since that time, they have worked together in the operating room or when Dr. Grazziano is out of the office, Dr. Grasso provides coverage. Over the years, he has personally observed Dr. Grasso in a medical practice and described him as a doctor with good hands, good academic learning and a compassionate feeling for his patients. Regarding Dr. Grasso's character, Dr. Grazziano stated that Dr. Grasso is very honest and that he does not think that he is deceptive.

Under cross examination, Dr. Grazziano reaffirmed his statement that Dr. Thompson did not tell him any specifics about the problems that Dr. Grasso was experiencing. The only suggestion made by Dr. Thompson, as Dr. Grazziano could recall, was that he should contact Dr. Canavan.

The final witness in mitigation, Dr. James Thompson, was sworn and questioned by Mr. Gorrell. Dr. Thompson first met Dr. Grasso in 1980 when he applied for residency training at St. Joseph's in Patterson. At all times Dr. Grasso displayed competence and completed his residency in the allotted time. Dr. Grasso exercised good judgement and technique in the use of forceps. When Dr. Grasso finished his program as a resident, the two discussed practice plans for the future. Dr. Thompson helped him obtain the position at Pascack Valley and over the next fifteen years kept in contact.

Dr. Thompson recalled contacting Dr. Grazziano for Dr. Grasso. As he remembered, he spoke with Dr. Grazziano and explained that Dr. Grasso had trained in his residency program, that he was a fine physician and that Dr. Grasso hoped to expand his practice in Dr. Grazziano's area. Concerning Dr. Grasso's character, Dr. Thompson stated that he always demonstrated the standard that it is hoped that younger physicians would have. He concluded by characterizing his demeanor with his patients as caring and pleasant. As far as Dr. Thompson could recall, he has never heard anything negative about Dr. Grasso.

D.A.G. Warhaftig cross-examined Dr. Thompson. Although Dr. Thompson could not specifically recall, he believed that he was aware of the allegations of professional misconduct raised by Dover Hospital against Dr.

Grasso. Also, he was aware of his summary suspension in 1991 from Passaic. Concerning Dr. Grasso's history of medical problems, Dr. Thompson believed it dealt with substance abuse and but he stressed that he had no first hand knowledge of that.

D.A.G. Warhaftig stated that there would be no witnesses from the State and she would submit the Attorney General's certification of cost.

Mr. Gorrell argued in conclusion that the Board has made certain findings against Dr. Grasso, but he believed that they were isolated findings of a period of time that occurred long ago. He continued by arguing that for the Board to restrict and sanction someone in the context of this case would be inappropriate. He asked the Board to remember that Dr. Grasso testified that he has had to renew his life on a couple of occasions. What the Board heard from the witnesses is that he has done that with honesty, competence, and integrity. Those people who know him and have worked with him and supervised him support him. For example, the Board heard Dr. Kierce who would refer his own family for a delivery. Although, much has been made by the Attorney General about so-called deception by Dr. Grasso, Dr. Grazziano who has known him for years and Dr. DiBella who investigated and questioned the nurses, have found no such evidence of this kind of behavior. To the contrary, he urged the Board to rely on the testimony of the mitigation witness who have stated under oath that Dr. Grasso is a highly competent, qualified physician. Because the findings of fact are based on incidents which allegedly took place years ago, nothing would be served by punishing Dr. Grasso for behavior which, even assuming it was true then, had no evidence of being present now. He requested that the Board not sanction Dr. Grasso and allow him to continue to practice medicine.

D.A.G. Warhaftig countered by stressing that Dr. Grasso has enjoyed a license to practice medicine in this State and that license is a privilege. It was the Attorney General's belief he is not worthy of that privilege and his license should be revoked. While Dr. Grasso sat before the Board and testified about how he prides himself on his high moral standards, D.A.G. Warhaftig was quick to remind the Board that he comes before it with a checkered history of dishonesty throughout his medical career. She asked the Board to consider his history which included trouble in a training program at a hospital which prohibited him from sitting for the FLEX that cause a delay in his licensure. After he was summarily suspended from Pascack and then, at St. Joseph's, he lost his position because of the AD case. He had no choice but to renew and rebuild his life because his career in this State had been filled with problems. She reminded the Board that in 1985, Board granted him a restricted license because it was aware that Dr. Grasso had encountered problems in medical school having issued prescriptions while a student, distributing the prescriptions to himself and a fellow student. At that time the Board was compassionate and gave him another chance. Yet, she argued, that the conduct which the Board learned about during the early part of his career was a foreshadowing of what Dr. Grasso's career as a licensee of this Board would be. Since that initial chance offered by the Board, Dr. Grasso has continued to deceive this Board, lying to a Committee of the Board, in sworn proceedings, in his medical records and to his patients. The character testimony heard during the hearing, she continued, does not outweigh the outrageous and deceptive behavior that has been a part of his professional practice. The Board offered Dr. Grasso a "second chance" once before and she urged the Board not to be as compassionate this time. She concluded by highlighting the various examples of how dangerous Dr. Grasso is to his patients and requested that the Board protect the citizens of this State by taking him out of practice by revoking that privilege that once was offered him --- the authority to practice medicine and surgery in the State of New Jersey.

The Board voted to go into executive session. Deputies, other than counseling staff, left the room, along with all other members of the public present.

The Board returned to opened session with all parties present and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED THAT DR. GRASSO RECEIVE A THREE-YEAR SUSPENSION, ONE YEAR TO BE AN ACTIVE SUSPENSION AND THE REMAINING TWO YEARS TO BE DEEMED A PERIOD OF PROBATION. THE BOARD FURTHER VOTED THAT AN APPEARANCE BEFORE A COMMITTEE OF THE BOARD IS TO BE HELD PRIOR TO THE RESUMPTION OF PRACTICE WITH THE CONDITIONS OF RE-ENTRY TO BE DETERMINED AT THAT

TIME. DR. GRASSO MUST ALSO TAKE AN ETHICS COURSE APPROVED BY THE BOARD PRIOR TO THE APPEARANCE BEFORE THE COMMITTEE OF THE BOARD. DR. GRASSO IS ASSESSED COSTS IN THE AMOUNT OF \$20,079.11 AND A PENALTY OF \$65,000. THIS ORDER IS EFFECTIVE 30 DAYS FROM ORAL ANNOUNCEMENT. A WRITTEN DETAILED ORDER WILL FOLLOW.

MEDICAL LABORATORY OF IRONBOUND (MLI), Newark, NJ
ROY, Pablo, M.D., License #19789, B.L.D., License #318
BOWMAN, Alan D., Esq., for Dr. Roy
PATEL, Chandrakant, M.D., License #37166, Lab. Owner
BROWN, Raymond A., & LaBUE, Anthony F., Esqs. For Dr. Patel
EHRENKRANTZ, Kay R., D.A.G. (Counseling Deputy: FLANZMAN)

(Proceedings recorded by Linda L. Mancuso-Psylos, C.S.R., GUY J. RENZI & ASSOCIATES)

Verified Complaint and Order to Show Cause filed May 28, 2002 seeking the temporary suspension of the licenses of Respondents Pablo Roy, M.D., and Chandrakant Patel, M.D., to practice medicine and surgery, and for Pablo Roy, B.L.D., to practice as a Bioanalytical Laboratory Director. The Application is based on a 17-Count Complaint which includes allegations against both physicians in Counts I through IX involving conduct at the Medical Laboratory of Ironbound (MLI) and the Universal Industrial Clinic (UIC); allegations against Dr. Roy in Counts X and XI including allegations that Dr. Roy failed to provide adequate management in his role as a laboratory director; and allegations against Dr. Patel in Counts XII through XVII that Dr. Patel referred patients to UIC and MLI for blood tests that UIC and/or MLI were not licensed to perform; failed to acquire a license for an MRI he used as a diagnostic service for patients; failed to properly label and process blood specimens; maintained expired and unsecured C.D.S. medication at his office; failed to comply with the Board's Patient Records Rule; and allegations that Dr. Patel lacks fundamental medical knowledge and engaged in acts of negligence and/or gross negligence in his care of specified patients.

MLI was closed pursuant to a Cease and Desist Order, Order of Summary Suspension of License and Notice of proposed Revocation of License, issued by the Department of Health. The Clinical Lab Director, Dr. Roy, and the lab owner, Dr. Patel, are both licensees of this Board.

The Board received under separate cover from the Division of Law the Order to Show Cause and Verified Complaint filed May 28, 2002. The Board received with its Supplemental Agenda D.A.G. Ehrenkrantz' letter filed June 7, 2002 amending the Verified Complaint and indicating that a formal amended Complaint will be subsequently provided. The Board also received with its Supplemental Agenda the Answer filed June 7, 2002, on behalf of Dr. Patel.

The Board also received as handouts D.A.G. Ehrenkrantz' June 10, 2002 letter in response to Dr. Patel's letter brief dated June 7, 2002; a June 5, 2002 letter from Venkataran S. Gandhi, M.D., concerning Dr. Patel taking his antidiabetic medications and not having anything to eat except for a glass of milk before he gave testimony before the Committee of the Board on April 30, 2002, likely resulting in hypoglycemia which is known to cause lack of concentration and the inability to answer questions appropriately; and Mr. LaBue's June 7, 2002 letter brief in support of Dr. Patel's opposition to the State's request to temporarily suspend his license to practice medicine and surgery in the State of New Jersey.

D.A.G. Ehrenkrantz and Mr. LaBue were present. With regard to the matter of Chandrakant Patel, M.D., Chairman Wallace noted for the record that he understood an agreement was reached. D.A.G. Ehrenkrantz read into the record the entire Interim Consent Order wherein:

Dr. Patel consents to voluntarily refrain from engaging in any aspect of the clinical practice of medicine in any setting whatsoever, commencing June 26, 2002, pending completion of the plenary hearing resolving the Amended Verified Complaint or until such time as he submits to an evaluation by a Board-approved focused education program and successfully completes any supplemental follow-up or remediation required by such evaluation program, subject to further review of such assessment and/or remediation by the Attorney General and the Board.

Dr. Patel is permitted to continue solely in an administrative capacity at Universal Industrial Clinic (UIC) and shall not direct the form or substance of any medical service provided to any patient treated by any other physician at UIC subject to the following conditions:

Within 21 days, Respondent shall hire a practice monitor approved by the Board, with all costs to be borne by Respondent, who will ensure that the practice at UIC operates in compliance with all regulations and statutes of the State of New Jersey pertaining to medical practice until such time as the Board modifies this Order or a final disposition by the Board is reached. Such practice protocols shall include, but not be limited to, the following:

Proper intake of patients seeking treatment or testing, including the taking and recording in the medical record of the medical history and present medical conditions for which such patients are seeking Universal Industrial Clinic's medical services;

Notation of patient's primary care physician or other treating physicians of individuals seeking medical services at UIC;

Preparation and maintenance of medical records in complete compliance with N.J.A.C. 13:35-6.5;

Referral of all patients to laboratories and diagnostic facilities made in compliance with the statutes and regulations governing the practice of medicine and surgery in the State of New Jersey and in compliance with the Clinical Laboratory Improvement Act and all other statutes and regulations governing laboratory practices of the State of New Jersey;

Proper communication of all laboratory results shall be made to patients, their physicians and their employers (where appropriate) and evidence of both the evaluation of the results and the communication of the results to the patient (or notice to the patient to schedule an office visit to communicate the results), physician and employer (where appropriate) shall be documented in the medical records;

Proper billing to both patients and third party payors in compliance with the statutes and regulations governing the practice of medicine and surgery in the State of New Jersey;

Proper maintenance and secured storage of all medication in compliance with the statutes and regulations governing the practice of medicine and surgery in the State of New Jersey; expired medications shall be properly removed; and proper maintenance and storage of laboratory specimens in compliance with the statutes and regulations governing the practice of medicine and surgery and laboratory practice in the State of New Jersey, including but not limited to, proper refrigeration and timely transport of such specimens. The practice monitor need not be present in the examination room during clinical examination or treatment. Such protocols shall be put in place within 30 days of the filing of this Order. Monthly reports demonstrating compliance shall be made to Board Medical Director Gluck by the Board-approved monitor until further Order of the Board. The first shall be provided 30 days after the monitor begins working at UIC.

The Board-approved practice monitor shall be provided with a copy of this Order by Respondent or his counsel, sign it and return the signed copy to the Board office with a copy to D.A.G. Kay Ehrenkrantz, and shall immediately report to the Attorney General (D.A.G. Kay Ehrenkrantz), and the Board (Executive Director William Roeder) any act in violation of this Interim Consent Order, including but not limited to, any clinical practice whatsoever by Respondent. Respondent and his counsel shall be notified of any such violation and the Attorney General may make any appropriate application for further discipline before the Board. Any response by Respondent and Counsel shall be limited to the issue of whether this Order has been violated.

The within voluntary cessation of clinical practice by Respondent is entered without admission of any wrongdoing on the part of Respondent and without prejudice to the further investigation and prosecution of this matter by the Attorney General of the State of New Jersey.

The terms of this Order shall remain in effect pending final disposition of the Administrative Complaint by the

Board or subsequent modification of the Order by the Board upon application by Respondent or the Attorney General.

D.A.G. Ehrenkrantz reported to the Board that this Interim Consent Order was signed by Dr. Patel and consented to as to form by Mr. Brown and will be signed by Mr. LaBue as well. Mr. LaBue stated that he had nothing to add and thanked the Board.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE THIS INTERIM CONSENT ORDER IN THE MATTER OF DR. PATEL.

D.A.G. Ehrenkrantz also briefly outlined the Consent Order of Temporary Suspension in the matter of Pablo Roy, M.D., B.L.D., wherein:

Dr. Roy is hereby temporarily suspended from the practice of medicine and surgery until the next scheduled meeting of the Board on July 10, 2002. Any additional adjournments must be requested in writing. THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE THE CONSENT ORDER OF TEMPORARY SUSPENSION IN THE MATTER OF DR. ROY.

OLD BUSINESS

1. BRAUNSTEIN, Philip, M.D., License #26560 (Without Appearance) BROWN, Joyce, D.A.G.

A Provisional Order of Discipline (POD) was filed March 25, 2002 which would revoke the above physician's license. Enclosed for Board consideration were D.A.G. Brown's April 24, 2002 letter to the Board; the POD with attachments filed March 25, 2002; and a proposed Consent Order signed by Dr. Braunstein. As noted in D.A.G. Brown's letter, Respondent indicated he was willing to enter into a Consent Order with this Board in which he agrees to voluntarily surrender his New Jersey license with prejudice to seeking further reinstatement. Therefore, instead of resolving this matter pursuant to the terms set forth in the POD, D.A.G. Brown recommends that the Board approve the terms set forth in the proposed Consent Order.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO APPROVE THE CONSENT ORDER SIGNED BY DR. BRAUNSTEIN AGREEING TO VOLUNTARILY SURRENDER HIS NEW JERSEY LICENSE WITH PREJUDICE TO SEEKING FURTHER REINSTATEMENT.

2. KALANI, Ghanshyam, M.D., License #57961 (Without Appearance) LaBUE, Anthony F., Esq., for Respondent PHAM, Jacqueline, D.A.G.

A Final Order of Discipline was filed by the Board on December 12, 2001, which revoked Dr. Kalani's license to practice medicine and surgery in this State. Enclosed were D.A.G. Pham's May 29, 2002 memo outlining this matter; Mr. LaBue's February 7, 2002 letter with attachments requesting that the Board set aside its December 12, 2001 Final Order of Discipline and reinstate the March 15, 2001 Provisional Order of Discipline while Dr. Kalani's Motion to Vacate his conviction and sentence is pending which was filed with the Federal Court in the Southern District of New York; and Mr. LaBue's May 29, 2002 letter renewing his request based on the attached May 1, 2002 Court Order that this matter will be considered by the Court. D.A.G. Pham suggests to the Board that if the New York Motion is successful and the conviction is vacated, then the Board entertain a Motion for Reconsideration of the Final Order of Discipline. She would not oppose that Motion. However, pending the outcome of the Motion to Vacate the New York conviction, the Final Order of Discipline should remain in effect, especially given the egregious conduct and the huge dollar amounts involved. D.A.G. Pham asked that the Board advise as to how to proceed.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO DENY MR. LABUE'S REQUEST TO SET ASIDE ITS DECEMBER 12, 2001 FINAL ORDER OF DISCIPLINE AND REINSTATE THE MARCH 15, 2001 PROVISIONAL ORDER OF DISCIPLINE WHILE DR. KALANI'S MOTION TO VACATE HIS

CONVICTION AND SENTENCE IS PENDING. THEREFORE, THE DECEMBER 12, 2001 FINAL ORDER WILL REMAIN IN EFFECT.

**3. PAYNE, John Bruce, D.O., License #38343 (Without appearance)
BROWN, Joyce, D.A.G.**

A Provisional Order of Discipline (POD) was filed March 22, 2002 which would reprimand the above physician. Enclosed for Board consideration were D.A.G. Brown's April 24, 2002 letter to the Board with attached Exhibits A through C and the POD with attachments filed March 22, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE PROVISIONAL ORDER OF DISCIPLINE WITH A FINAL ORDER OF DISCIPLINE. Mr. Walsh abstained from vote in this matter.

**4. SAUL, Barry J., M.D., License #36659 (Without appearance)
LaBUE, Anthony F., Esq., for Respondent
GARCIA, Alexandra, D.A.G.**

A Provisional Order of Discipline (POD) was filed January 28, 2002 which would actively suspend the above physician's license for six months beginning on the day this Order becomes final. Enclosed for Board consideration were D.A.G. Garcia's May 30, 2002 letter to the Board, Mr. LaBue's April 16, 2002 response; and the POD with attachments filed January 28, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE PROVISIONAL ORDER OF DISCIPLINE WITH A FINAL ORDER OF DISCIPLINE. THE BOARD, AT ITS AUGUST 14, 2002 MEETING, AMENDED THIS MOTION TO SAY IT VOTED TO WITHDRAW THE PROVISIONAL ORDER OF DISCIPLINE IN THE MATTER OF DR. SAUL.

**5. FINALIZATION OF PROVISIONAL ORDERS OF DISCIPLINE
BROWN, Joyce, D.A.G.**

Enclosed for Board reviewed was D.A.G. Brown's May 7, 2002 letter to the Board concerning Provisional Orders of Discipline (PODs) filed with respect to each of the ten physicians listed below. Each matter was subject to finalization 30 days after issuance and no responses were received. The Attorney General sought entry of Final Orders of Discipline without modification for each of the physicians listed below.

1. BECK, Alan Gerson, M.D., License #26458

A POD was filed February 5, 2002 which would suspend the above physician's license until such time as he demonstrates that he holds an unrestricted Pennsylvania license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

2. CORINES, Peter J., M.D., License #36324

A POD was filed February 4, 2002 which would revoke the above physician's license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

3. GOORAHOO, Paul L., M.D., License #42993

A POD was filed January 30, 2002 which would revoke the above physician's license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

4. HAINES, Jeffrey, M.D., License #48509

A POD was filed January 30, 2002 which would suspend the above physician's license until such time as he can

demonstrate that his New Hampshire license is unrestricted. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

5. HICKS, James T., M.D.

A POD was filed March 25, 2002 which would revoke the above physician's license. Although a response to the POD has not yet been received, Executive Director Roeder is unable to sign an Affidavit until the Administrative Office receives the certified return receipt concerning service.

6. LOCNIKAR, Steven J., D.O., License #52629

A POD was filed January 30, 2002 which would revoke the above physician's license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

7. MOHEBBAN, Farhad, M.D., License #51997

A POD was filed February 4, 2002 which would revoke the above physician's license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

8. MOSHER, Richard H., M.D., License #41734

A POD was filed January 30, 2002 which would suspend the above physician's license until such time as he can demonstrate that he holds either an unrestricted Iowa license or an unrestricted Pennsylvania license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

9. SCHUMERT, Raphael, M.D., License #42276

A POD was filed February 4, 2002 which would reprimand the above physician and require him to successfully complete a Board-approved recordkeeping course prior to resuming active practice in New Jersey. Enclosed was Executive Director Roeder's May 29, 2002 Affidavit with attachments.

10. WOLFE, Gerald L., D.O., License #21629

A POD was filed January 28, 2002 which would revoke the above physician's license. Enclosed was Executive Director Roeder's May 21, 2002 Affidavit with attachments.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE PROVISIONAL ORDERS OF DISCIPLINE WITH FINAL ORDERS OF DISCIPLINE FOR THE ABOVE PHYSICIANS WITH THE EXCEPTION OF JAMES T. HICKS, M.D. THE BOARD VOTED TO FINALIZE THE PROVISIONAL ORDER OF DISCIPLINE CONCERNING DR. HICKS WITH A FINAL ORDER OF DISCIPLINE UPON RECEIPT OF THE AFFIDAVIT FROM EXECUTIVE DIRECTOR ROEDER.

REPORT OF NEW COMPLAINTS FILED

1. PATEL, Chandrakant, M.D., License #37166 (Edison, NJ)

Verified Complaint filed May 28, 2002 alleging gross and repeated acts of malpractice, negligence, incompetency; professional misconduct; dishonesty, fraud, deception or misrepresentation; incapable of discharging the functions of a licensee in a manner consistent with public health; continued practice present clear and imminent danger to the public; general responsibility; failure to maintain adequate records; aided/abetted an unlicensed entity in performing function requiring licensure; expired medications - unsecured CDS medications; and violation of Patient Record Rule.

2. ROY, Pablo, M.D., License #MA19789 and B.L.D., License #MF0000318 (Newark, NJ)

Verified Complaint filed May 28, 2002 alleging gross and repeated acts of malpractice, negligence, incompetency; professional misconduct; dishonesty, fraud, deception or misrepresentation; incapable of discharging the functions of a licensee in a manner consistent with public health; continued practice present clear and imminent danger to the public; general responsibility; failure to maintain adequate records; aided/abetted an unlicensed entity in performing function requiring licensure; expired medications - unsecured CDS medications; and violation of Patient Record Rule.

REPORT OF INTERIM AND FINAL ORDERS FILED WITH THE BOARD

1. FIKS, Juan Bernardo, M.D., License #MA25592 (Tenafly, NJ)

FINAL ORDER OF DISCIPLINE filed May 20, 2002. On or about January 9, 2001, Dr. Fiks entered into a Consent Agreement and Order with the New York Board wherein he agreed not to contest the second specification in full satisfaction of the charges against him. On or about May 21, 1999, he was treating an eight-year-old child when, for no legitimate purpose, he slapped the child across the face. He was charged with professional misconduct by engaging in moral unfitness to practice medicine, which he did not contest. His New York license was suspended for 60 months, with six months as an active suspension after which he would be placed on probation for five years. Based on the New York action, a Provisional Order of Discipline was filed with this Board. Through counsel, he responded and advised he had not practiced medicine in New York or New Jersey since January 9, 2001. The Board ordered his New Jersey license be suspended for 60 months, with six months active retroactive to January 9, 2001 and 54 months stayed to be served as probation should he seek to resume practice in New Jersey. Prior to resuming active practice in New Jersey, he must appear before the Board to demonstrate fitness to practice. Any practice prior to said appearance shall constitute grounds for a charge of unlicensed practice. The Board reserved the right to place restrictions on his license should it be reinstated. EFFECTIVE DATE: January 9, 2001

2. FISHTEIN, Mark B., D.O., License #MB64494 (Malvern, PA)

ORDER OF DISMISSAL OF PROVISIONAL ORDER filed January 29, 2002. A Provisional Order of Discipline was filed on August 28, 2001 based on actions which had been taken against Dr. Fishtein's licenses in the States of Pennsylvania and Missouri. Dr. Fishtein submitted mitigating information and provided an affidavit which demonstrated he had fully disclosed those actions to the New Jersey Board at the time of initial licensure. Since the Board investigated the issues prior to granting licensure and since he has practiced in New Jersey for six years with no negative information reported to the Board, the Board has ordered the Provisional Order of Discipline filed August 28, 2001 be dismissed. EFFECTIVE: January 29, 2002

3. GANGEMI, Frederick D., M.D., License #MA43402 (Belleville, NJ)

ORDER GRANTING UNRESTRICTED LICENSURE filed March 25, 2002. On or about October 8, 1999, Dr. Gangemi's license to practice medicine and surgery in the State of New Jersey was temporarily suspended due to a substance abuse problem. On November 8, 2000, he signed a Consent Order in which his license was reinstated with conditions. In January 2002, he petitioned the Board for an unrestricted license. The Board is satisfied he had successfully participated with the monitoring program of the Physicians' Health Program and had been totally compliant with his recovery regimen. The Board ordered he be granted an unrestricted license to practice medicine and surgery in the State of New Jersey. EFFECTIVE DATE: March 25, 2002

4. JECK, Charles N. D.O., License #MB53808 (Mercerville, NJ)

INTERIM CONSENT ORDER filed May 8, 2002. An Order to Show Cause and Verified Complaint were filed May 1, 2002 seeking the temporary suspension of Dr. Jeck's license to practice medicine and surgery in the State of New Jersey pending a hearing on allegations that he indiscriminately prescribed controlled dangerous substances and engaged in sexual misconduct with two of his female patients. He consented to an interim disposition. The Board ordered Dr. Jeck's license to practice medicine and surgery in the State of New Jersey be temporarily suspended effective June 1, 2002 and until further order of the Board. From May 8, 2002 until May 31, 2002, he may wind down his practice. He may see current patients but must cease/desist from accepting any

new patients to his practice. He must cease/desist prescribing or dispensing any controlled dangerous substances in any form. He must employ a Board-approved New Jersey licensed health care provider to act as monitor and be present at all times when he is with patients. Monitor required to sign all patient charts. Matter is to be referred to the Office of Administrative Law for hearing. EFFECTIVE DATE: May 8, 2002

5. LIN, Chiang L., M.D., License #MA26319 (Holmdel, NJ)

CONSENT ORDER filed May 8, 2002. The Board received information that Dr. Lin engaged in negligence by failing to appropriately respond to patients in his care at Marlboro Psychiatric Hospital. The Board considered all three incidents. Although the problems confronted by Dr. Lin were institutional in nature, including the requirement that Dr. Lin, a psychiatrist, performed the functions of a medical physician, the Board found he had not provided adequate care to three patients. The Board ordered Dr. Lin's license be suspended for three years with the suspension stayed to be served as probation. His practice is to be limited to psychiatry until further order of the Board. At the end of probation, he must appear before a Committee of the Board. Assessed \$7,500.00 penalty and \$1,853.61 investigative costs. EFFECTIVE DATE: May 8, 2002

6. LOFTUS, James B., M.D., License #53247 (Harvey Cedars, NJ)

MODIFIED CONSENT ORDER OF RESTRICTED LICENSURE filed April 2, 2002. Dr. Loftus petitioned the Board for modification of the Order of Restricted Licensure dated May 22, 2000. As a result of that Consent Order, he continues to work in a surgical center in Toms River. Since he is the main anesthesiologist, he wished to secure Schedules III, IV and V privileges for facility credentialing purposes and thus allowing the facility to receive proper reimbursement from insurance programs. He does not plan to use CDS III, IV, and V in his practice. The Board ordered that Dr. Loftus have his privileges to prescribe CDS Schedules III, IV and V restored. He may discontinue Naltrexone. He must submit to random, unannounced weekly urine monitoring under supervision of the Physicians' Health Program (PHP) for six months. PHP to report quarterly to the Board and immediately report any positive urine screen results to the Executive Director of the Board. Failure to submit to urine monitoring will be deemed equivalent to a confirmed positive. He will be employed only at the Ocean Endosurgery Center in Toms River, New Jersey, under supervision of Judah Schorr, M.D., and may not take any part-time employment or volunteer work in the field of medicine. Dr. Schorr is to provide quarterly reports to the Board. Dr. Loftus must continue attendance at support groups, continue in counseling on a bi-weekly basis with quarterly reports to the Board. He must maintain absolute abstinence from alcohol and all psychoactive substances unless prescribed by a treating physician for a documented medical condition. Should the Board receive proof that Dr. Loftus has violated the terms and conditions of this Order, the Board may summarily suspend or limit his license pending a hearing on those charges. EFFECTIVE DATE: April 2, 2002

MODIFIED CONSENT ORDER OF RESTRICTED LICENSURE filed May 20, 2002. On April 2, 2002, a Modified consent Order of Restricted Licensure was filed. This new order modifies further the conditions under which Dr. Loftus may be employed. He will be employed only as an independent contractor in a Board approved facility under supervision of Judah Schorr, M.D., and may not take part-time employment or volunteer work in the field of medicine. Dr. Schorr must submit quarterly reports to the Board pertaining to Dr. Loftus' work and continued abstention from mood-altering drugs. All other conditions of the Modified Consent Order of Restricted Licensure filed April 2, 2002 remain in place. EFFECTIVE DATE: May 20, 2002

7. MAURO, Alfred L., M.D., License #MA21829 (Demarest, NJ)

CONSENT ORDER filed May 10, 2002. The Board received information that Dr. Mauro prescribed significant quantities of controlled substances, primarily Percocet and Methadone, to nine patients between January 1998 and August 2000. He appeared before a Committee of the Board to answer questions concerning his prescribing and also his recordkeeping. He testified he had proactively made significant changes to his office procedures and employed a registered nurse to review every patient record. The Board ordered he be reprimanded for indiscriminate prescribing of controlled substances and failure to keep proper records. He agreed to submit patient charts to the Board's Medical Director for quarterly review and to complete Board-approved courses in the proper prescribing of controlled dangerous substances and recordkeeping. He was assessed investigative costs of

\$11,172.59. EFFECTIVE DATE: May 10, 2002

8. MORGENSTERN, Glenn M., M.D., License #MA50135 (Tinton Falls, NJ)

CONSENT ORDER filed April 25, 2002. Dr. Morgenstern has complied with certain terms of the Interim Consent Order filed January 15, 2002. The evaluation required by the Interim Consent Order confirmed he was remorseful and there was no disorder predictive of current or future misconduct. The Board ordered his license be suspended for two years with the first six months as an active suspension effective May 15, 2002 and the remainder served as probation contingent upon his compliance with the conditions of this Order. Assessed \$5,000.00 penalty and costs to be determined. He must appear before a Committee of the Board prior to reinstatement of active licensure. Upon reinstatement, he must be monitored by a licensed female health care professional who will report monthly to the Board. He must continue his participation with the Physicians' Health Program (PHP). PHP to provide the Board with quarterly reports and immediate reporting of noncompliance. He must continue psychiatric treatment with a Board-approved mental health professional who will report quarterly to the Board. EFFECTIVE DATE: May 15, 2002

9. NAPOLI, Salvatore, M.D., License #50431 (Maywood, NJ)

ORDER GRANTING UNRESTRICTED LICENSURE filed March 28, 2002. On January 2, 2002, Dr. Napoli appeared before a PEC to petition for an unrestricted license. Both Dr. Napoli and Dr. Canavan from the Physicians' Health Program (PHP) testified at length with regard to Dr. Napoli's recovery and his successful participation in the PHP monitoring program. The Board was satisfied he had been totally compliant with his recovery program and ordered he be granted an unrestricted license. EFFECTIVE DATE: March 28, 2002

10. O'CONNELL, Mark, M.D., License #MA65676 (Neptune, NJ)

CONSENT ORDER OF VOLUNTARY SURRENDER OF LICENSURE filed May 8, 2002. The Board received information from the Physicians' Health Program (PHP) that Dr. O'Connell admitted to diverting Fentanyl from patients in the Intensive Care Unit at Jersey Shore Medical Center, thus establishing a relapse into substance abuse. The Board ordered Dr. O'Connell be granted leave to immediately surrender his license to practice medicine and surgery in the State of New Jersey for a minimum of three months. Prior to any restoration of licensure, he must appear before a Committee of the Board to demonstrate fitness to re-enter practice and that he is not then suffering any impairment or limitation which could affect his practice. EFFECTIVE DATE: May 8, 2002

11. WRIGHTSON, John, M.D., License #MA69675 (New Wilmington, PA)

ORDER GRANTING UNRESTRICTED LICENSURE filed September 19, 2001. Dr. Wrightson petitioned the Board for an unrestricted license. On 9/3/99, he had entered into a Consent Order of Limited Licensure which granted him a NJ license but limited his practice solely to the Sportsmedicine Fellowship at Kessler Institute, prohibited acquiring a CDS/DEA number and required participation with the Physicians' Health Program (PHP), including urine monitoring. A report from the PHP advised Dr. Wrightson had been fully compliant with their requirements. His Pennsylvania license had been restored without restriction. The Board ordered Dr. Wrightson be granted an unrestricted license to practice medicine and surgery in the State of New Jersey. EFFECTIVE DATE: September 19, 2001

LICENSURE MATTERS

1. BRONSTEIN, Michael, Athletic Trainer, License #1070 issued 10/29/01 (Old Bridge, NJ)

FINAL DECISION AND ORDER filed November 5, 2001. The Board received information that Mr. Bronstein had been practicing athletic training from August 1999 to June 2001 at Wardlaw-Hartridge School without having first obtained a registration. During the application process, the Board also received information that he had been practicing athletic training at Highland Park High School. The Board ordered that he be granted a

registration to practice athletic training in the State of New Jersey. The Board also ordered that he be reprimanded for the unregistered practice of athletic training and required to pay a \$460.00 penalty.

**2. CASTANEDA, Edson Peter, Athletic Trainer (License #1053 issued 8/21/01)
(Monmouth Junction, NJ)**

CONSENT ORDER filed January 9, 2002. The Board received information that Mr. Castaneda had been practicing athletic training from February 1997 until May 2001 at various high schools in New Jersey after his temporary registration to practice athletic training had expired. He applied for and has been granted a registration to practice athletic training in this State. The Board ordered he be reprimanded for the unregistered practice of athletic training. He was ordered to pay a penalty of \$390.00.

**3. CAYWARD, Heather, Athletic Trainer, License #1080 issued 12/18/01
(Guttenberg, NJ)**

CONSENT ORDER filed November 28, 2001. The Board received information that Ms. Cayward had been employed as an assistant athletic trainer from November 2000 until June 2001 at the Stevens Institute of Technology without having first obtained a registration. She applied for a registration in June 2001. The Board ordered she be granted a registration to practice athletic training in the State of New Jersey. The Board also ordered she be reprimanded for the unregistered practice of athletic training and required to pay a \$250.00 penalty.

4. CENTRELLA, Michael, D.O., (Unlicensed) (Edison, NJ)

CONSENT ORDER GRANTING A RESIDENCY TRAINING PERMIT WITH CONDITIONS AND WITHDRAWAL OF PLENARY MEDICAL LICENSE APPLICATION filed December 21, 2001. During the licensure application process, Dr. Centrella disclosed his 12-year history of dependence of psychoactive substances and his multiple relapses. In 1989, he withdrew an application for New Jersey licensure and was then granted a residency training permit subject to conditions set forth in an April 3, 1990 public Consent Order. The Board considered that the Minnesota and Pennsylvania Licensing Boards have entered public orders based on conduct related to impairment, inappropriate prescribing and voluntary surrender of a controlled substance permit. Additionally, he had been excluded from participation in Medicare/Medicaid and effective January 1999 was debarred from the Federal Health Benefit Program. The Board considered his three years of documented sobriety and his active involvement with the New Jersey Physicians' Health Program (PHP). The Board ordered Dr. Centrella be granted a residency training permit to participate in an Addictive Psychiatry Residency Training Program at Robert Wood Johnson and shall withdraw his application for a plenary New Jersey medical license. Dr. Centrella must enroll in the New Jersey PHP and comply with a monitoring program including urine monitoring. PHP to immediately report to the Board any positive urine screen, failure to submit or provide a urine sample, and/or discontinued attendance at support groups. In the event Dr. Centrella travels out of State for any reason, he must advise the PHP and make arrangements for urine testing within 24 hours of return to the State. PHP to report quarterly to the Board. Dr. Centrella must engage in substance abuse and mental health counseling with Ricardo Fernandez, M.D., at least once a month, with an evaluation provided to the Board by February 2002. May not prescribe or dispense Controlled Dangerous Substances for himself nor shall he possess such substances except pursuant to a bona fide prescription written by a physician or dentist for good medical/dental cause. Physician/dentist who prescribes shall provide written report to the Medical Director of the Board and PHP along with patient records. Continued residency permit status with restrictions contingent on strict compliance with all conditions. Upon the Board's receipt of any information indicating any term(s) have been violated, a hearing shall be held before the Board or its authorized representative. May apply for modification of the conditions of this Order no sooner than one year from the date of entry. Dr. Centrella's application for a plenary license is withdrawn. The Board will not entertain any reapplication until his psychiatric evaluation is received and he has completed six months of therapy as well as a performance evaluation from his residency program director.

**5. CONROY, Sean Dennis, Athletic Trainer, License #1076 issued 12/4/01
(Hackettstown, NJ)**

FINAL DECISION AND ORDER filed December 15, 2001. The Board received information that Mr. Conroy had practiced athletic training from 1999 to the present for the Morris County Secondary Schools' Ice Hockey League and from January 2000 to June 2001 at the Oak Knoll School in Summit, New Jersey, without having first obtained registration. The Board ordered he be granted a registration. The Board also ordered that he be reprimanded for the unregistered practice of athletic training and required to pay a penalty of \$320.00.

**6. DAVIES, Kevin, Athletic Trainer, License #1083 issued 2/4/02
(Hackettstown, NJ)**

CONSENT ORDER filed February 4, 2002. The Board received information that Mr. Davies had been practicing athletic training from August 1999 to the present at Centenary College in the State of New Jersey without having first obtained a registration. The Board ordered he be granted a registration. The Board also ordered that he be reprimanded for the unregistered practice of athletic training and required to pay a \$375.00 penalty.

**7. EGAN, Anthony Michael, Athletic Trainer, License #1015
issued 1/5/01 (Bayonne, NJ)**

FINAL DECISION AND ORDER filed September 18, 2001.

The Board received information that Mr. Egan had been practicing athletic training from August 1999 to January 5, 2001 at Marist High School and from September to December 1997 when he served as an assistant athletic trainer at Westfield High School, without first having obtained registration. The Board ordered he be reprimanded for the unregistered practice of athletic training. He was ordered to pay a \$250.00 penalty.

**8. OLEAN, Roger T., Athletic Trainer, License #1081 issued 12/18/01
(Bellevue, PA)**

FINAL DECISION AND ORDER filed January 9, 2002. The Board received information that Mr. Olean had been practicing athletic training from September 2000 until the present at the NJ Institute of Technology without having first obtained a registration. He applied for a registration in July 2001. The Board ordered he be granted a registration to practice athletic training. The Board also ordered he be reprimanded for the unregistered practice of athletic training and ordered to pay a penalty of \$285.00.

**9. RAGGAZINO, Francis, Athletic Trainer, License #1050 issued 8/13/01
(Dresher, PA)**

FINAL DECISION AND ORDER filed August 16, 2001. The Board received information that Mr. Raggazino had been practicing athletic training from 1995 until the present, first at Seton Hall University from August 1995 until July 1998 and then at Monmouth University without having first obtained a registration. The Board ordered that he be granted a registration. The Board also ordered that he be reprimanded for the unregistered practice of athletic training and pay a penalty of \$1,000.00.

10. TOMKO, Richard, Athletic Trainer, Unlicensed (Fairlawn, NJ)

FINAL DECISION AND ORDER filed October 4, 2001. The Board office received information that Richard Tomko had been represented as an athletic trainer and was practicing athletic training from September 1999 to June 2001 at Dunellen High School. He had signed a contract with the Dunellen School District. He maintained he served as an assistant football coach and denied any intent to violate the law. The Board ordered and Mr. Tomko agreed to cease and desist representing himself as an athletic trainer in the State of New Jersey. He was required to pay a \$250.00 penalty.

Additional matters which are not considered public reports were filed with the Board Office.

Respectfully submitted,

David M. Wallace, M.D., Chairperson
for Open Disciplinary Matters

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