

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

August 14, 2002

A meeting of the New Jersey State Board of Medical Examiners was held on Wednesday, August 14, 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, Moussa, Patel, Paul, Perry, Ricketti, Robins, Rokosz, Trayner, Wallace and Walsh

EXCUSED

Board members Desmond, Huston, Lucas and Weiss

ALSO PRESENT

Deputy Attorneys General Dick, Ehrenkrantz, Flanzman, Gelber, Harper, Kenny, Joyce, Levine and Warhaftig; Executive Director Roeder and Medical Director Gluck

RATIFICATION OF MINUTES

The Minutes from the July 10, 2002 Board meeting were approved as submitted.

HEARINGS, PLEAS, RETURN DATES, APPEARANCES

**10:00 a.m. - ANDUJAR, Edward, M.D., License #52473(Counseling Deputy: FLANZMAN)
TESTA, Michael and HERNANDEZ, Jose, Esqs., for Respondent
HARPER, Douglas J., D.A.G., for Complainant**

Order to Show Cause and Complaint filed August 6, 2002 seeking the entry of an Order imposing such disciplinary sanctions as the Board may find necessary and appropriate including, but not limited to, revocation or suspension of licensure or an order temporarily suspending licensure pending final decision on the Complaint.

An Order of Temporary Limitation on License was filed by the Board on March 28, 2002 preliminarily finding that Dr. Andujar had maintained and utilized office premises which were unsafe and unsanitary. Said conditions thereafter were remedied and in the event that any drug or other substance, including, but not limited to, vitamins or antibiotics is intravenously administered to a patient of Dr. Andujar's, he was directed that said treatment shall be initiated, monitored and terminated only by a physician or physician assistant licensed by the Board who is competent in intravenous administration, a registered professional nurse licensed by the Board of Nursing who is competent in intravenous administration, or a licensed practical nurse licensed by the Board of Nursing who is specially trained in intravenous administration as established by the Board of Nursing Guidelines.

The Complaint alleges Dr. Andujar was served with this March 28, 2002 Order and subsequent to the entry and service of said Order in violation thereof, Dr. Andujar caused and permitted the intravenous infusion of drugs, and/or other substances to be initiated, monitored and terminated for his patients by individuals who were not licensed as contemplated by the Board's Order. The Complaint further alleges that Dr. Andujar violated his duty to cooperate in an inspection and investigation conducted on behalf of the Board on July 17, 2002. Enclosed are

the Order to Show Cause and Complaint with attachments filed August 6, 2002.

Prior to the meeting, this matter was adjourned by Dr. Harrer because the parties were able to reach on interim settlement position. The parties agreed that the most recent complaint would be consolidated with the prior complaint, both matters to be heard at the October Board meeting. The Order also included terms to limit Dr. Andujar's practice with pre-designated times with a monitor in place, as well as heightened inspection capabilities. Any violation of the Order would permit an application for immediate suspension of Dr. Andujar's license upon application to the Board president. The Board was satisfied that the interim settlement agreement was protection of the health, safety and welfare of the citizens of New Jersey.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO RATIFY DR. HARRER'S APPROVAL OF THE TERMS OF THE ORDER. Dr. Robins voted in opposition.

**1:00 p.m. - PELLIGRA, John P., M.D. (Counseling Deputy: LEVINE)
KERN, Steven I., and WEIR, Bonnie M., Attorneys for Respondent
KEOSKEY, Alex J., D.A.G., for Complainant**

Dr. Wallace is recused from this matter.

Matter set down for mitigation. The Board heard oral argument on exceptions in the matter of John P. Pelligra, M.D., at its May 8, 2002 meeting, at which time the mitigation portion was adjourned until a later date. Enclosed for Board review is the April 17, 2002 Initial Decision of Administrative Law Judge M. Kathleen Duncan. This matter was initiated based upon a Complaint filed May 1, 2000 alleging gross negligence, malpractice, incompetence; dishonesty, deception; and failure to comply with Board regulation. Enclosed are the following documents which the Board had before it at its May meeting: the Administrative Complaint filed May 1, 2000; Respondent's Answer to the Administrative Complaint filed May 10, 2000; Amended Answer to the Administrative Complaint filed October 26, 2000; and D.A.G. Keoskey's Exceptions filed April 30, 2002 which includes the Stipulations between the parties and the deposition of Albert L. Strunk, M.D., Complainant's expert; and Respondent's Reply filed May 6, 2002 to the Complainant's Written Exceptions to the Initial Decision. At its May meeting, the Board determined to reinstate the Complaint in order to consider whether to impose sanctions. Also enclosed are the condensed copy of the transcript of the May 8, 2002 proceeding before the Board and the May 8, 2002, Open Disciplinary Minutes in the matter of Dr. Pelligra.

Mr. Kern began by reminding the Board that the ALJ specifically found that Dr. Pelligra's addition to the patient record was not with the purpose to conceal any wrongdoing, but rather to make the record complete. In fact, Mr. Kern continued, there is nothing in the record which supports the theory that Dr. Pelligra was attempting to mislead or conceal any wrongdoing concerning the care received by the patient. During the mitigation hearing, Mr. Kern believed that the testimony would show that Dr. Pelligra is not a dishonest person and that the people that know him and respect him have always encountered him to be an ethical person. This entire ordeal has taken a significant toll on Dr. Pelligra and his family and he urged the Board to finally put an end to the injustice. In mitigation, Mr. Kern called the following witnesses.

Laura McDonough testified on behalf of Dr. Pelligra. She first came to know him as he obstetrician after she was referred to him by a friend. According to the witness, Dr. Pelligra has always provided thorough and caring treatment. In February of 1997, she had a baby and she recalled that her labor had to be induced. Shortly after she arrived at the hospital, Dr. Pelligra also arrived at the hospital and explained everything to her and her husband. Basically, he walked her through the entire procedure. She was aware that he was going to be leaving the hospital as it might take some time. The nurses continued to check on her at regular intervals and eventually, she had to have an emergency C-section. She delivered a baby which had to be admitted to the pediatric ICU, although she did not recall the reason. She subsequently has had two more children delivered by Dr. Pelligra. Ms. McDonough has been satisfied with the care provided by Dr. Pelligra and has referred many patients to him.

George Laubach, M.D. has been licensed in New Jersey since 1967 and is the immediate past chair of the OB/GYN department at Jersey Shore Medical Center. He has worked with Dr. Pelligra over the years, supervised his work, and observed him interacting with both patients and staff members. Dr. Laubach stated that he has

never had any problems with Dr. Pelligra, particularly as it related to medical records. He first became aware about the situation with this "changed" record as part of his membership on the Quality Assurance Committee in the hospital. According to Dr. Laubach, it was hospital protocol that when an emergent C-Section took place, the medical records are copied after the procedure is completed. When the records were compared to what was copied against subsequent copies of the medical records, the addition was noted. It was Dr. Laubach's opinion that no material change was made to the record. The Committee, although it noted the change, determined that the change was made more as a clarification rather than as alteration of the record. After learning of the change, he spoke with Dr. Pelligra and informed him it was not the appropriate way to change a record. According to Dr. Laubach, Pelligra readily admitted that he added some information and explained that he only did it so that the record would be complete. Dr. Laubach believed that Dr. Pelligra understood it to be a clarification, not a change in the record. For a year to a year and a half, Dr. Laubach reviewed Dr. Pelligra's charts and never found anything negative about his documentation. Dr. Laubach also noted for the Board that at the time that this occurred, no procedure was in place at the hospital concerning the proper procedure to "change" a record.

Carl Lepis testified that he has been a licensed physician in New Jersey for the past twenty two years as an OB/GYN. He has known Dr. Pelligra as a member of the staff at Jersey Shore Medical Center and has the highest regard for him. He understood why Dr. Pelligra added information to the record because it has been his experience that it is not always easy to write contemporaneous notes with an emergency procedure. As a general rule, he leaves a space in the chart, so that he can go back at a later time and fill in the information. For example, it is not uncommon in his experience that a resident will write in the operative report and leave space above so that the pre-operative narrative can be filled in at a later time.

Dr. Lepis informed the Board that he has personally witnessed the effect that this matter has had on Dr. Pelligra. Although Dr. Pelligra has continued to provide quality care to his patients, Dr. Lepis has noticed a significant change in his personality insofar as Dr. Pelligra appears to be sad all the time. There was no doubt in Dr. Lepis mind that Dr. Pelligra is an honest and ethical individual.

Joseph Canterino was also called as a character witness for Dr. Pelligra. Dr. Canterino also is an OB/GYN and has known Dr. Pelligra for approximately eleven years. In that time, Dr. Canterino has been contacted as a consultant for Dr. Pelligra's patients, in particular those with high risk conditions. Dr. Canterino has reviewed Dr. Pelligra's records over the years and has always found that they conform to the appropriate standards. He described the records as complete and thorough. Dr. Canterino also commented on the impact that this has had, noting that Dr. Pelligra's demeanor has changed. Dr. Canterino characterized his mood as sullen and stated that the entire ordeal has been draining on Dr. Pelligra, as well as his family.

Noel Aikman stated that he as known Dr. Pelligra as both his teacher and his colleague. He described Dr. Pelligra as an excellent physician. He went on to inform the Board that Dr. Pelligra is well respected within in the community and has always provided the highest quality of care to his patients.

Susan Pelligra, his wife, appeared before the Board and informed the members that this entire process has had a tremendous impact on her husband. Prior the charges brought by the Board, she described her husband as happy, energetic, a "super dad" who also had time for the neighborhood children. Since the filing of the complaint, her husband has been sad, quiet, almost "embarrassed", and with little or no time for his family or friends. As a general rule, he keeps to himself and the matter has consumed him to the point where that is all that seems to be on his mind. She begged the Board to put an end to his pain.

Finally, Dr. Pelligra addressed the Board. He began by stressing that he did nothing wrong with the care of his patient and therefore, he had nothing to hide or conceal. The worst nightmare of his life, he continued, began five years ago when he put a note into a patient record and forgot to initial and date it. When he realized that the hospital was reviewing his chart, he told the Board, he sought out the advice at the hospital, and he was told to add the new information. As a former Marine, he listened to his chain of command and did what he was told. Dr. Pelligra asked the Board to believe him that he did not add anything to the record except for the purpose of clarification. He was not adding anything new and since he did nothing wrong in the care of the patient, he had nothing to hide or misrepresent.

Dr. Pelligra also asked the Board to take into consideration the impact that this has had in his life. When the trial at the Office of Administrative Law began, it was reported all over the Asbury Park Press - in many ways, he believed that he was tried in the press. It was so difficult for his family that when he learned that his own daughter had read the articles, he fell to the ground in embarrassment. He pleaded with the Board to put an end to this nightmare and let him get back to the practice of medicine.

Mr. Kern concluded the mitigation hearing by asking the Board to realize that there were no quality of care issues in the case. With that in mind, the Board should conclude that Dr. Pelligra had nothing to hide in light of the fact that the care was appropriate. At best, Mr. Kern argued, this case was about a technical violation of a Board rule, not a case of dishonesty and misrepresentation. He asked the Board to take into consideration the suffering that Dr. Pelligra has undergone over the six years to bring this matter to a conclusion and not impose any sanctions against Dr. Pelligra's license to practice medicine and surgery in the State of New Jersey.

In rebuttal, D.A.G. Keoskey referenced the findings of the Administrative Law Judge in which it was determined that the additions to the record were done to avoid further review and criticism. He argued that Dr. Pelligra's addition was done to protect his own interest and to prevent further questions about his care to this patient. In light of this attempt to deceive and misrepresent the record, D.A.G. Keoskey requested that the Board enter a Public Order sanctioning Dr. Pelligra for this behavior.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED THAT DR. PELLIGRA VIOLATED THE BOARD'S RECORD RULE. IN CONSIDERATION, HOWEVER, OF THE UNIQUE AND COMPELLING MITIGATION INFORMATION, THE BOARD ALSO HAS DETERMINED THAT REMEDIAL MEASURES HAVE BEEN TAKEN BY THE LICENSEE AND THE BOARD IS ASSURED THAT THIS CONDUCT WILL NOT OCCUR IN THE FUTURE. THEREFORE, THE BOARD WILL NOT IMPOSE ANY DISCIPLINARY SANCTIONS AGAINST THE LICENSEE. UPON APPLICATION BY THE ATTORNEY GENERAL'S OFFICE, WITH AN OPPORTUNITY FOR RESPONDENT TO RESPOND IN WRITING, THE BOARD WILL ENTERTAIN A MOTION FOR THE IMPOSITION OF COSTS.

LOPEZ, Jose, M.D. (Counseling Deputy: JOYCE)
BERNHARD, Matthew B., Esq., for Respondent
BEY-LAWSON, Hakima, D.A.G., for Complainant

This matter was before the Board a for hearing on Order to Show Cause filed August 9, 2002 and Verified Complaint filed August 12, 2002 seeking the immediate temporary suspension of Dr. Lopez' license to practice medicine and surgery. The eight-Count Verified Complaint alleges Respondent's medical treatment of R.R., M.L., C.G., V.V., C.H. and W.N. constitutes gross and repeated acts of negligence, malpractice or incompetence; that Respondent's course of conduct demonstrates multiple violations of the Board's Surgical and Anesthesia Regulations thus demonstrating professional misconduct and a failure to comply with a regulation administered by the Board; and Respondent's course of conduct demonstrates that his continued practice of medicine presents a clear and imminent danger to the public health, safety and welfare. The Verified Complaint further alleges in Count VII a course of conduct demonstrating a violation of the Board's Duty to Cooperate Regulation; failure to maintain contemporaneous patients records in violation of the Board's Patient Records Rule thus demonstrating professional misconduct and a failure to comply with a regulation administered by the Board; and Count VIII alleges failure to maintain malpractice insurance in violation of a Board regulation and his course of conduct alleged in this Count constitutes dishonesty, fraud, deception or misrepresentation; professional misconduct; the lack of good moral character, and demonstrates a violation of the Board's Duty to Cooperate Regulation and Malpractice Coverage Regulation.

Enclosed for Board consideration were the Order to Show Cause filed August 9, 2002; Verified Complaint and Appendix filed August 12, 2002, D.A.G. Bey-Lawson's Certification filed August 12, 2002; the c.v. of State Expert Paul J. LoVerme, M.D., and D.A.G. Bey-Lawson's August 12, 2002 letter in support of the Attorney General's emergent application

The Board began the hearing on the Attorney General's application with D.A.G. Bey Lawson presenting her

opening remarks. Dr. Lopez did not appear, however, through counsel, represented that he was presently in China and was due to return to the United States on August 20, 2002. Counsel further represented that Dr. Lopez was requesting an adjournment of the proceedings to allow him to respond to the charges and that he would consent to the entry of an order of temporary suspension in New Jersey, as well as all other jurisdictions (foreign and domestic), until such further order from the Board. D.A.G. Bey Lawson objected to the adjournment. The Board, however, determined to enter the order of temporary suspension and to allow the respondent the opportunity to petition the Board to be heard at its September 11, 2002 meeting. In the event that the respondent does not file such a petition, the Board, will, on the Attorney General's request, schedule the matter for hearing at the October Board meeting.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO TEMPORARILY SUSPEND DR. LOPEZ' LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY AND THAT HE SHALL CEASE AND DESIST FROM THE PRACTICE OF MEDICINE IN NEW JERSEY AND ALL OTHER JURISDICTIONS FOREIGN AND DOMESTIC, UNTIL FURTHER ORDER OF THE BOARD. THE BOARD GRANTED RESPONDENT LEAVE TO RESPOND TO THE CHARGES AT THE BOARD MEETING ON SEPTEMBER 11, 2002, UPON THE FILING OF A PETITION AND SUBMISSION OF SUPPORTING MATERIALS, NO LATER THAN AUGUST 28, 2002. IN THE EVENT THAT RESPONDENT DOES NOT FILE SUCH AN PETITION, THE BOARD WILL ENTERTAIN THE ATTORNEY GENERAL'S APPLICATION FOR TEMPORARY SUSPENSION AT ITS REGULARLY SCHEDULED MEETING IN OCTOBER.

OLD BUSINESS

1. GANTI, Shashi D., M.D., License #59944 MANTEL, Donna Lee, Esq., for Respondent ALBERTSON, B. Michelle, D.A.G.

A Provisional Order of Discipline (POD) was filed September 18, 2001 which would revoke the above physician's license. Enclosed for Board consideration are D.A.G. Albertson's July 16, 2002 letter to the Board, Ms. Mantel's letters of October 1, 2001 and May 14, 2002, the POD with attachments filed September 18, 2001, and an Interim Consent Order filed January 10, 1995. The enclosures listed by Ms. Mantel in her May 14, 2002 letter are provided to the Board with its Closed Agenda. The Attorney General requests that the Board sustain its Findings of Fact and Conclusions of Law with the proposed modifications suggested by D.A.G. Albertson. However, as to penalty, the Attorney General believes that the Board may wish to grant Respondent's request for a mitigation hearing to present any evidence or testimony as to why his license should not be revoked.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO TABLE DECISION ON THIS MATTER.

2. NASEERUDDIN, Khaja, M.D., #41882 FRUCHTMAN, Susan, Esq., for Respondent PHAM, Jacqueline, D.A.G.

A Provisional Order of Discipline (POD) was filed March 15, 2001 which would revoke the above physician's license. The Board, at its September 19, 2001 meeting, voted to finalize the POD with a Final Order of Discipline (FOD). It appears the FOD was never submitted to the Administrative Office for filing or served on Dr. Naseeruddin. Enclosed for Board consideration are D.A.G. Pham's July 23, 2002 letter to the Board; Mr. LaBue's July 12, 2001 response with attachments which the Board had before it at its September meeting; Ms. Fruchtman's July 2, 2002 letter with attachment; and the POD with attachments filed March 15, 2001. Ms. Fruchtman has requested that the POD be reconsidered and the Board issue an Order limiting Dr. Naseeruddin's practice of medicine to a federal facility such as a Veterans Affairs Medical Center. D.A.G. Pham believes Dr. Naseeruddin should not now benefit because the FOD has not been filed and his request is nothing more than a request to reconsider the POD, which she states should not be granted, as Dr. Naseeruddin fails to offer any additional information other than the fact that he wishes to apply for a position at the Veterans Affairs Hospital in

Oregon. D.A.G. Pham requests Board advice on how to proceed in this matter.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO TABLE DECISION ON THIS MATTER.

3. PLOTNIK, Peter (Pyotr) J., M.D., License #47092
HOCHRON, Stuart M., Esq., for Respondent
PHAM, Jacqueline, D.A.G., for Complainant

A Provisional Order of Discipline (POD) was filed March 25, 2002 which would revoke the above physician's license. Enclosed for Board consideration are D.A.G. Pham's May 6, 2002 letter to the Board, Mr. Hochron's April 22, 2002 response with attachments, and the POD with attachments filed March 25, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO TABLE DECISION ON THIS MATTER.

4. RAMANADHAM, Aruna, M.D., License #49440
QUIAT, Michael E., Esq., for Respondent
PHAM, Jacqueline, D.A.G., for Complainant

A Provisional Order of Discipline (POD) was filed May 7, 2002 which would issue a reprimand to the above physician. Enclosed for Board consideration are D.A.G. Pham's July 23, 2002 letter to the Board, Mr. Quiat's letters of July 3 and August 5, 2002, and the POD with attachments filed May 7, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE PROVISIONAL ORDER OF DISCIPLINE.

5. SCOTT, Gerald Alan, M.D.
GORRELL, Joseph M., Esq., for Respondent
KEARNS, Anthony P., III, D.A.G., for Complainant

In accordance with a Consent Order filed March 4, 2002 in the matter of Dr. Scott, Dr. Scott shall enroll in and successfully complete a recordkeeping course approved by this Board within six months of the entry of this Consent Order. The Board, at its July 10, 2002 meeting, received a June 10, 2002 letter from Mr. Gorrell attaching the registration completed by Dr. Scott to take the Medical Recordkeeping Symposium offered by William Vilensky, D.O., on September 27, 2002. The Board, at its July meeting, approved the taking of this course by Dr. Scott in accordance with the Consent Order. Enclosed are an August 5, 2002 letter from Mr. Gorrell with attachments and the Consent Order filed March 4, 2002. As noted, the course was canceled for the fall session due to lack of registrants. Mr. Gorrell's letter indicates that on February 15, 2001, Dr. Scott completed a documentation course through the AMA, for which he was credited with 3.5 hours of C.M.E. Mr. Gorrell's submission includes a description of an additional on-line course in recordkeeping for physicians. In view of the cancellation of Dr. Vilensky's course, Mr. Gorrell requests that the Board approve these two courses for compliance with the Consent Order of March 4, 2002.

Dr. Robins recused from discussion and vote in this matter and left the table.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO ACCEPT THE RECORDKEEPING COURSE.

6. SUMNER, Michael G., M.D., License #30756
ABRAMSON, Neil M., Esq., for Respondent
ALBERTSON, B. Michelle, D.A.G.

A Provisional Order of Discipline (POD) was filed March 22, 2002 which would issue a reprimand to the above physician and order that he successfully take and pass a Board-approved ethics course. Enclosed for Board

consideration are D.A.G. Albertson's July 17, 2002 letter to the Board, Mr. Abramson's April 9, 2002 response, and the POD with attachments filed March 22, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE PROVISIONAL ORDER OF DISCIPLINE AS AMENDED IN CORRECTING THE DATE.

There being no further business of the Board concerning Disciplinary Matters Pending Conclusion in open session, the Board voted to continue with the meeting concerning Matters Pending Litigation and Disciplinary Action in closed session.

Respectfully submitted,

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

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