

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

September 11, 2002

A meeting of the New Jersey State Board of Medical Examiners was held on Wednesday, September 11, 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**

Board Members Criss, Farrell, Haddad, Harrer, Lucas, Moussa, Patel, Paul, Perry, Ricketti, Trayner, Wallace, Walsh and Weiss

**EXCUSED**

Board Members Chen, Desmond, Huston, Robins, and Rokosz.

**ALSO PRESENT**

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

**RATIFICATION OF MINUTES**

The Minutes from the August 14, 2002 Board meeting were approved as submitted.

**HEARINGS, PLEAS, RETURN DATES, APPEARANCES**

**10:00 a.m. - CITARELLI, Louis J., M.D. (Counseling Deputy: FLANZMAN)  
D'ALESSIO, Michael, Jr., Esq.  
KENNY, Paul R., D.A.G., Appearing for HARPER, Douglas J., D.A.G.**

Matter was set down for mitigation. Dr. Citarelli's license to practice medicine had been temporarily suspended by Board Order filed September 30, 1998; thereafter, a second order was entered on May 3, 2000 continuing the temporary suspension, granting judgment on an amended Complaint to the Attorney General, and ordering that any determination as to a final penalty should be deferred until a mitigation hearing is held, with the mitigation hearing to be scheduled after Dr. Citarelli was sentenced in federal court. Mr. D'Alessio submitted the enclosed March 28, 2002 letter with attachments to include a copy of the April 12, 2000 transcript of the proceeding before the Board. Mr. D'Alessio's letter advised that Dr. Citarelli was sentenced in federal court, and Mr. D'Alessio therefore asked that the Board schedule a mitigation hearing. Mr. D'Alessio's letter also contained a motion seeking the disqualification of D.A.G. Harper as counsel in this matter which was denied by the Board at its May 8, 2002 meeting. Enclosed was Executive Director Roeder's May 14, 2002 letter advising D.A.G. Harper and Mr. D'Alessio of the Board's May 8, 2002 decision concerning the Board's denial of the motion seeking disqualification of D.A.G. Harper.

Also enclosed was Executive Director Roeder's July 9, 2002 letter to D.A.G. Harper and Mr. D'Alessio advising them that Board President Harrer granted the adjournment from the Board's July 10th meeting and the request from Mr. D'Alessio that the matter not be scheduled for the Board's August 14th meeting. Therefore, the hearing to decide the penalty to be imposed in this matter had been rescheduled for this meeting.

Also enclosed was Mr. D'Alessio's June 18, 2002 letter which included two separate Judgments of Conviction, 30 letters of recommendation, as well as three promises of employment, and letters from Columbus Hospital and Clara Maass Medical Center. Also enclosed was D.A.G. Harper's letter brief filed August 20, 2002 and appendix in support of the Attorney General's cross motion for the entry of a final order revoking licensure based upon Dr. Citarelli's convictions on a one-count federal indictment and three-count information charging bribery and conspiracy to commit bribery, mail and wire fraud, and to defraud the Internal Revenue Service.

Dr. Citarelli expressed appreciation for the opportunity to address the Board members about the nightmare that he has lived over the past several years. He believed the entire ordeal has strengthened his character and has forced him to reflect on many things. Dr. Citarelli acknowledged that he was remorseful for what he did and assured the Board that he takes full responsibility for his actions. He further believed that something good has come out of a bad situation. Dr. Citarelli confirmed that he has made full restitution and has complied with all the terms of the Order. He asked the Board to return him to practice so that he could once again be the caring and compassionate physician that he always was. He promised to dedicate himself to the highest professional standards, certifying that he would never make the same personal or professional mistakes that he has made in the past. Upon questioning, he outlined the continuing medical education courses that he has taken since he has been out of practice since 1998. His efforts in this regard consisted of reading materials and attendance at some courses.

In mitigation, his attorney added that the Board should put Dr. Citarelli's actions into context. At the time of the incident, Dr. Citarelli was undergoing a bitter divorce and in his stupidity, he attempted to hide income from his wife. He stressed that Dr. Citarelli's actions had nothing to do with patient care and there were no quality of care issues as part of this matter. Mr. D'Alessio requested that the Board use its common sense and conclude that Dr. Citarelli does not pose a danger to the public. He also assured the Board that Dr. Citarelli is committed to dedicating himself to providing caring, compassionate and professional care to his patients. Although Mr. D'Alessio did not believe there was any reason for the Board to be concerned about returning Dr. Citarelli to the practice of medicine, he proffered that if the Board did have concerns, Dr. Citarelli would be amenable to any restrictions that would allay the Board's concerns. This was a case of bad judgment, Mr. D'Alessio concluded, and not a case of bad medicine.

D.A.G. Kenny, appearing in substitution for D.A.G. Harper on this adjourned date, began his presentation with a summary of the facts. The real issue, according to D.A.G. Kenny, is whether Dr. Citarelli possesses the good moral character demanded of a licensee of the Board. He reminded the Board that this was a case of more than just a mere indiscretion. Dr. Citarelli pled guilty to an elaborate scheme to defraud large amounts of money, filed false claims and then, hid the money. While Dr. Citarelli honestly admitted to fully cooperating with the authorities, D.A.G. Kenny postulated that it was in Dr. Citarelli's best interest to do so. His actions should not be viewed as one of high moral character because his cooperation was self-serving - it reduced his jail time. D.A.G. Kenny reminded the Board of similar cases in which the licensee cooperated with the authorities, and in those case, revoked the license. He posited that the same result was merited by the facts of this case.

The Board voted to go into executive session for deliberations. 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 members of the public present, and announced the following motion:

**THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO REVOKE DR. CITARELLI'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY AND FURTHER ORDERED DR. CITARELLI TO PAY COSTS.**

Mr. Walsh did not participate in the discussion and vote in this matter.

**11:00 a.m. - CHANG, Ming Z., M.D. (Counseling Deputy: LEVINE)  
KERN, Steven I., Esq., and WEIR, Bonnie, Esq., for Respondent  
GELBER, Joan D., D.A.G., for Complainant**

Matter was set down for hearing in the matter of Ming Z. Chang, M.D. Enclosed for Board review was the June

20, 2002 UNREDACTED COPY of the Initial Decision of Administrative Law Judge Elinor R. Reiner. This decision contained patient names and Board members were cautioned to avoid verbal references to actual names. This matter was initiated based upon a three-Count Complaint filed June 18, 1999 alleging in Count I that Dr. Chang engaged in a pattern of radiological practice that violated various provisions of Title 45 and certain administrative regulations pertaining thereto; alleging in Count II defacement or alteration of patient records (which was withdrawn by Complainant at the OAL hearing); and alleging in Count III that Dr. Chang was a second offender since he had been the subject of a Board disciplinary order on June 26, 1991 for violation of accepted standards of medical practice, including misrepresentation of patient diagnosis and other forms of misconduct. Enclosed were the Administrative Complaint filed June 18, 1999, Answer and Affirmative Defenses filed August 16, 1999, and D.A.G. Gelber's limited Exceptions dated July 5, 2002.

Trial Defense counsel in this matter, Mr. Gorrell, requested an extension of time in which to file exceptions and an adjournment from the Board's August 14, 2002 meeting until the Board's September 11, 2002 meeting for consideration of the Initial Decision and Exceptions. Submissions were submitted by the prosecuting deputy in opposition to said requests. Because defense counsel noticed the Board that her firm is now substitute counsel, Board President Harrer granted an extension for submission of Respondent's Exceptions until August 1, 2002 and granted an adjournment of the consideration of this matter until the Board's September 11, 2002 meeting. Enclosed was Dr. Harrer's July 23, 2002 letter sent to the parties concerning this issue.

Also enclosed were Respondent's Written Exceptions filed July 31, 2002 (Without the Exhibits); D.A.G. Gelber's Response to the Exceptions submitted by Defense and Motion to Exclude Material Not Part of the OAL Record; Certification of Joan D. Gelber filed August 9, 2002; Mr. Kern's August 13, 2002 Motion to Reopen and Motion to conduct written depositions of the State's experts; D.A.G. Gelber's August 19, 2002 Reiterated Motion to Exclude Proffered Documents which were not a Part of the Trial Record, and Opposition to Respondent's New Motion to Reopen the Record; and Board President Harrer's August 28, 2002 letter to the parties.

Board President Harrer preliminarily determined, subject to Board consideration at the meeting, that the attachments to Respondent's Exceptions were not presented as evidence at the hearing and were to be excluded at this juncture as violative of N.J.A.C. 1:1-18.4(c). The attachments to Respondent's Exceptions were not included with the packet, however, copies were available at the meeting in a sealed folder.

Board President Harrer also reviewed Respondent's Motion to conduct post-trial written depositions of the State's experts and preliminarily determined, subject to Board consideration at the meeting, that the Board not order the written depositions.

The Board considered the parties Exceptions to the Initial Decision and in the alternative Respondent's Motion to Reopen.

Prior to the hearing, the Board voted to go into executive session for deliberations. 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 members of the public present, and announced that it would begin with a limited hearing as to whether to admit the attachments to Respondent's Exceptions in the consideration of this matter.

Prior to oral argument on this issue, Mr. Kern requested to poll the Board members as to whether any Board member, either personally, professionally, or through an associated group practice, has been represented by the Brach Eichler law firm. In particular, if a Board member is a shareholder in the practice, Mr. Kern requested that it be disclosed and furthermore, that the Board member consider recusal in this matter.

The Board voted to go into executive session for deliberations. 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 members of the public present, and announced that the Board members were given the opportunity to raise with counsel whether any relationship exists or existed with the

Brach Eichler firm which would necessitate a recusal in participating in the matter. The Board further announced that after advice from counsel, no such relationship exists that would inhibit or impede a Board member from rendering a fair and impartial decision in this matter.

The Board further disclosed that Dr. Perry is personally represented by the firm and although he does not believe that it would prohibit him from rendering an impartial decision, given the uniqueness of the posture of this case, Dr. Perry would recuse from participating in this hearing. Dr. Perry left the table. (Dr. Robins had previously recused from this case).

D.A.G. Gelber opened her remarks by asking the Board to deny her opposing counsel's request to include the exhibits into consideration of the matter. The inclusion of this information, according to D.A.G. Gelber, at this juncture would be patently violative of the rules of the Administrative Procedure Act. This case is before the Board after ten days of trial from which a detailed, well-reasoned decision from the Administrative Law Judge was written. She continued by pointing out that the Board has that decision and an extensive record before it. At trial, counsel for Dr. Chang put forth a vigorous defense. D.A.G. Gelber further explained that the new defense counsel now wishes to "reopen" the record by submitting additional evidence. In essence, defense counsel is asking that the trial never end. If these documents were so crucial to Dr. Chang's defense, she postulated, then the documents should have been entered into evidence during the extensive trial. Even if the Board were to determine that a conflict of interest existed, although the Attorney General's office maintained that none did, D.A.G. Gelber argued that its existence did not materially affect the outcome of the case.

Mr. Kern took exception to D.A.G. Gelber's characterization of the issue. He did not view his motion as one that would allow him to add to the record below. He argued that his motion concerned legal issues, namely a conflict of interest, not raised at the trial level. Mr. Kern explained that Dr. Chang was not aware of the impact of the conflict of interest until after the trial concluded particularly because of Mr. Gorrell's failure to inform Dr. Chang of the firm's relationship with some of the witnesses. Mr. Kern maintained that because of the conflict a vigorous defense was not provided inasmuch as Mr. Gorrell did not submit the appropriate evidence, did not perform an effective cross-examination, did not call certain witnesses and did not properly prepare witnesses for testimony. He submitted that the exhibits he wished to introduce were not to supplement the record, but rather to demonstrate and provide support that Dr. Chang was not provided with an appropriate legal representation. Mr. Kern outlined the various conflict of interests that he believed existed with the various witnesses.

The Board voted to go into executive session for deliberations. 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 members of the public present, and announced the following motion:

**THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO RATIFY BOARD PRESIDENT HARRER'S DECISION TO DENY THE APPLICATION TO TAKE POST-TRIAL WRITTEN DEPOSITIONS OF THE STATE'S EXPERTS.**

**THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO DENY DR. CHANG'S MOTION TO RE-OPEN THE RECORD.**

**FINALLY, THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO ADOPT IN ITS ENTIRETY THE ADMINISTRATIVE LAW JUDGE'S FINDINGS OF FACT AND CONCLUSIONS OF LAW, THEREBY, DENYING THE ATTORNEY GENERAL'S EXCEPTIONS TO THE DECISION.**

Mr. Kern then requested additional time for oral argument on specific exceptions to the written decision as he thought the Board was only entertaining argument on whether to allow the exhibits into evidence and, in the alternative, to reopen the matter because of the alleged conflict of interest issue.

**THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO DENY THE REQUEST FOR ADDITIONAL ORAL ARGUMENT. THE OPPORTUNITY TO PRESENT ORAL ARGUMENT IS DISCRETIONARY AND ALL PAPERS SUBMITTED AND CONSIDERED WERE ENTITLED**

## EXCEPTIONS.

The Board proceeded to the hearing on mitigation.

Mr. Kern presented Judge Ustes, an attorney that practices family law and serves as a municipal judge. She has known Dr. Chang since 1985 when he became her treating physician. Prior to attending law school, Ms. Ustes worked for a developer and she became acquainted with Dr. Chang when he purchased a building from the developer. She always has found Dr. Chang to be a caring and compassionate doctor and friend. She assured the Board that if something went awry with his practice, it certainly was not intentional. Dr. Chang, Ms. Ustes continued, has always been of assistance to her and anyone she has referred to Dr. Chang. She implored the Board to take into consideration the mitigating factors of Dr. Chang's commitment to serving his patients in such a professional and caring matter. At the end of her testimony, approximately thirty people stood in support of her words.

Mr. Joseph LiPari, a real estate developer and volunteer fire chief, also addressed the Board. Mr. LiPari first told the Board that he was to attend 911 ceremonies in New York because he had participated in the tragic event last year, but chose to give that up because of his admiration for Dr. Chang. His family has been treated by him over the years and Dr. Chang has always been a consummate professional. Dr. Chang literally saved the life of his child by finding a dysfunctional kidney that had been missed by other medical providers. Prior to being examined by Dr. Chang, his son was experiencing terrible headaches and the other doctors were not able to determine the etiology. Dr. Chang, in contrast, immediately discovered that he was suffering from a brain tumor. In his opinion, Dr. Chang was unique in the medical field because he takes the time to talk and listen to his patients rather than just write a prescription and send them on their way. He concluded by expressing his opinion that to take Dr. Chang's license would have a devastating impact on the community.

The next witness in mitigation, the Reverend Moses Yang, spoke to the Board about his ten-year relationship with Dr. Chang. He was suffering from terrible allergies and no one seemed to be able to help him. A friend of his referred him to Dr. Chang and Dr. Chang cured him. He has sent his whole family to Dr. Chang because of the excellent medical treatment they receive. To take away his license, according to Reverend Yang, would have a calamitous effect on the community, in particular on the Asian American community.

Dr. Huey Jen Lee, a radiologist, began his presentation by reviewing his educational and professional background. He has personally and professionally known Dr. Chang for the last ten years. Dr. Lee has found Dr. Chang's diagnoses to be quite accurate and has interacted with him in second opinion discussions on countless occasions. Dr. Lee, although he did not believe it necessary, offered to monitor Dr. Chang's radiological readings if that would provide a level of comfort to the Board.

Finally, Dr. Chang offered testimony before the Board. After reviewing his educational and professional background, Dr. Chang addressed his continuing education efforts. He believed he was current in his medical knowledge. Additionally, Dr. Chang informed the Board that he was well-respected in the community and always treated his patients compassionately. He thanked all of his patients that have offered their support to him and apologized to them for this ordeal. Dr. Chang asked the Board to continue to let him practice and assured the Board that he has learned from his mistakes. He asked the Board to believe him that he would never do anything like this again.

Ms. Gelber, in closing, reminded the Board that in determining the appropriate discipline, the Board should take into account the administrative law judge's findings. She pointed out that the judge found, in at least twenty patients, a pattern of improper diagnosing that rose to a level of gross negligence. This improper diagnosis could have resulted in either the patient receiving unnecessary treatment or, in some cases, no treatment at all. Such a practice, D.A.G. Gelber maintained, constitutes a danger to the public. She urged the Board to impose the strictest sanction, some remedial conditions, and costs.

Mr. Kern, in rebuttal, directed the Board's attention to the issues in the case. He argued that there will always be a disagreement among radiologists and the State's own expert testified that it can happen in about 10 percent of the cases. With that in mind, the number of readings at issue would be less than half of the cases presented. He also

reminded the Board of the testimony that it heard from the various patients that came to this hearing. Each and every one of them have been completely satisfied with the care received from Dr. Chang. He postulated that the people at the meeting are but a small portion of members of Dr. Chang's community who have always received quality of care from him. While he urged the Board to not impose any disciplinary sanction, Mr. Kern asked the Board to fashion the appropriate remedy. Mr. Kern offered that because the only issue concerned Dr. Chang's radiology practice, the Board could reinstate Dr. Chang's license with a monitor restriction. Ultimately, however, he argued that the most appropriate decision by the Board would be to reserve decision on the matter until Dr. Chang has raised the legal issue concerning the conflict of interest at the appellate level.

The Board voted to go into executive session for deliberations. 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 members of the public present, and announced the following motion:

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO SUSPEND DR. CHANG'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY FOR TWO YEARS, THE FIRST OF WHICH SHALL BE ACTIVE, THE SECOND TO BE SERVED AS PROBATION. THE BOARD FURTHER ORDERED THE PAYMENT OF SECOND OFFENDER PENALTY AND COSTS OF WHICH AMOUNT WAS REDUCED BY THE \$760.00 ALREADY PAID.

THE BOARD ALSO ADOPTED ALL OTHER REMEDIAL ACTIONS RECOMMENDED BY THE ADMINISTRATIVE LAW JUDGE.

THE BOARD VOTED UNANIMOUSLY TO DENY MR. KERN'S MOTION FOR A STAY OF THE BOARD ORDER.

**1:00 p.m. - 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 at its August 14, 2002 meeting at which time the Board voted to enter an Order of Temporary Suspension and to allow Dr. Lopez the opportunity to petition the Board to be heard at this meeting. Matter set down 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 are 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., D.A.G. Bey-Lawson's August 12, 2002 letter in support of the Attorney General's emergent application; Order of Temporary Suspension filed August 20, 2002; Respondent's Certification in Opposition to Order to Show Cause filed August 28, 2002 with Exhibits A through J and Answer filed August 28, 2002.

D.A.G. Bey-Lawson opened by asserting to the Board that the Attorney General is seeking a temporary suspension of Dr. Lopez' license based on the poor quality of treatment of six patients who sought out Dr. Lopez for certain cosmetic procedures. The complications that resulted from these procedures, she argued, constituted gross negligence and repeated acts of negligence that present a clear and imminent danger to the health, safety and welfare of the citizens of New Jersey. She further argued that the proofs submitted by the Attorney General, which included the office records for the patients, the hospital records, the submitted sworn statements, and the State's expert report, establish the necessary grounds to grant the Attorney General's application for a temporary suspension.

Mr. Bernhard, counsel for Dr. Lopez, opened by thanking the Board for the opportunity to be heard. He postulated that after the Board reviewed the evidence that Dr. Lopez would present it would conclude that Dr. Lopez' treatment of the patients was within the current standards of medical care. He believed that the Attorney General's case was seriously flawed insofar as the Attorney General has made simple, cursory assertions as to the appropriate standard of care. Dr. Lopez, in his defense, will submit evidence from the literature and scholarly works to support the standards used by him. He argued further that the Attorney General was confusing complications, which are always a potential with any type of surgery, with negligence. Simply because there are unavoidable complications from surgery, the Board should not equate those outcomes with negligence. Mr. Bernhard continued by telling the Board that Dr. Lopez already has suffered irreparable harm with the filing of the Temporary Suspension and the delay in which Dr. Lopez was able to respond. Mr. Bernhard argued that the Attorney General's filing of the application for Temporary Suspension was somewhat disingenuous since it knew that Dr. Lopez was out of the country. With the filing of the temporary suspension, Dr. Lopez has suffered humiliation and in many ways, according to Mr. Bernhard, his practice has been ruined with the coverage of this matter in the press.

D.A.G. Bey-Lawson moved the following exhibits into evidence: P-1 office records for RR; P-2 hospital records for RR; P-3 prescription log for RR; P-4 office records for ML and MB; P-5 hospital records for ML and MB; P-6 office records for CG; P-7 transcript of PEC hearing of July 2002; P-8 office records for VV; P-9 transcript of hearing February 2002; P-10 Certification of Dr. Gardner; P-11 sworn statement of VV; P-12 sworn statement of CG; P-13 sworn statement of VV (daughter of ZB, R.N.); P-14 hospital records of CH; P-15 hospital records of WN; P-15 office records for WN; P-17 certification of Kathleen Conklin, Enforcement Bureau; P-18 certification of Dr. LoVerne (State's expert witness); P-19 Curriculum Vitae of Dr. LoVerne; P-20 medical incident report of WN; P-21 Supplemental certification of Dr. LoVerne; P-22 certification of Rafael LaTorre, M.D. Hearing no objection from Mr. Bernhard, the Board entered into evidence the above listed exhibits.

Mr. Bernhard then moved the following into evidence: Certification and attached exhibits of Dr. Lopez' written submission, previously marked as exhibits A through J, marked as Exhibits R-1 through R-10 for purposes of this hearing; R-11, article from the New York Post to demonstrate the irreparable harm suffered by Dr. Lopez; and R-12 references to current medical literature cited in Dr. Lopez' certification. Upon further consultation by the parties, it was agreed to eliminate certain items from R-12, which included an article by Vachia Scarborough, Chapter 9 (authored by Rodney, Lauin, and Jullie) and the Atlas Cosmetic Surgery reference. Also, Patient CG's pictures were not included. Also, although, the State did not object to the entry of R-11 into evidence, it was noted that the document did not indicate the source. The Board entered into evidence Exhibits R-1 through R-12.

Dr. Lopez addressed the Board by explaining that he reviewed the State's expert certification concerning his opinion of the use of excessive dosages of lidocaine. He went on to explain that there are some material issues with the standards that the State expert is using. He acknowledged that at one time 35mg per kilo was an appropriate standard. Dr. Lopez further explained that this was the standard in or about 1990. In 1993, he went on, the standard changed to 55mg per kilo. He referred the Board to the literature he provided to verify the current recommended dosage. Dr. Lopez specifically mentioned the Columbia manual, which actually states a range of 50 to 60 mg per kilo and the Harvard University article. He posited that the Board would be hard pressed to find current literature support for the standard used by Dr. LoVerne in his certification.

Dr. Lopez then addressed the State contention that there was a gross deviation from the appropriate standard of medical care in patient CG. Dr. Lopez acknowledged that CG suffered from skin necrosis following the

liposuction, but was quick to point out that this is a common complication with this procedure. He urged the Board not to succumb to the Attorney General's apparent conclusion that a risk inherent in the surgery equates to negligence in the performance. Again, he argued that current literature supports Dr. Lopez' argument that the skin necrosis can be a common occurrence with liposuction surgery. The Attorney General also argues that CG was not an appropriate candidate for the surgery. Dr. Lopez countered this assertion by arguing that the current literature acknowledges that liposuction is a changing field of surgery and supports surgery for a patient such as CG when separated into a two-stage procedure with the use of local anesthesia. A Class II abdominal procedure, according to Dr. Lopez, is down staged in order to minimize the complications which might normally occur. He urged the Board, after its review of the literature provided, to conclude that the State's expert used outdated standards in rendering his opinion.

Addressing the State's contention that the use of naprosyn is not appropriate for acute, postoperative pain, Dr. Lopez argued that the American Academy of Anesthesia indicates that it is appropriate. In any event, Dr. Lopez continued, that although he may have recommended it, if the Board reviews R-3, the office record, it demonstrates that it was never used.

Turning the Board's attention to patients ML and BD, Dr. Lopez informed the Board that bleeding is a well-known complication which is well documented in the literature and various studies. He argued that the State's expert once again is equating a known risk with negligence. According to Dr. Lopez, experts in the field have documented that there is a one to three percent bleeding rate as a normal complication associated with liposuction. In reviewing his records for the past six months, Dr. Lopez told the Board that he has only had two patients that have fallen within this risk factor.

Dr. Lopez admitted that he was surprised that the care of patients ML and VV were part of the Attorney General's submission. He has already addressed those cases which occurred more than two years ago.

Concerning the State's assertion that his treatment of WN with sedated anesthesia was inappropriate, Dr. Lopez pointed out that R-6 illustrates that there are two schools of thought on this. The literature indicates that there are a number of procedures today that are appropriate for both local and/or sedated anesthesia. He urged the Board not to conclude that his use, which is supported in the literature, of sedated anesthesia in this case was negligent.

In reviewing the medical records for patient RR, Dr. Lopez argued that it was inconceivable for a patient to have gone for thirteen days with a bowel perforation without any of the attending symptoms. The hospital records also indicate that RR was seen by at least six other physicians over the course of the thirteen days, and no one detected it. No pathology was taken and other test results did not indicate a bowel perforation. The patient continued to experience acute abdominal pain and an abdominal debridement was performed. He posited that during that procedure is when the bowel perforation occurred.

Finally, Dr. Lopez addressed the Board concerning the irreparable harm he has suffered with the filing of the Temporary Suspension. He is a well-recognized member in his community, he continued, and while in Columbia was a Senator. Prior to this hearing, he was a medical correspondent for a radio station and public TV. According to Dr. Lopez, he has suffered humiliation and his practice has been ruined because the State's expert has based his opinion on out-dated standards that are no longer supportable by current medical literature.

On cross-examination, D.A.G. Bey-Lawson established that Dr. Lopez did a four-year residency in clinical, surgical pathology. The additional training in plastics was taken in Columbia and he has not received any plastics training in the United States. The only hospital privilege (surgical/dermatology) that Dr. Lopez testified he has held was at Columbus Hospital in 1994 through 1995.

Concerning the treatment of the six patients at issues in the Verified Complaint, Dr. Lopez was the only qualified licensee to administer conscious sedation present during the procedures of RR, ML, CH and WN. Dr. Lopez recalled that with CG and VV, two medical assistants were also present with him. He used the medical assistants in his practice to take blood pressure, draw blood, perform verbal consults with the patient, take the vital signs, and to assist him in surgery by passing him the instruments. After his appearance before a committee of the Board, the committee recommended that he hire a nurse. He followed that recommendation, although the nurse

quit after about three or four months of employment.

Specifically, D.A.G. Bey-Lawson questioned Dr. Lopez about patient CH. Dr. Lopez recalled speaking to Dr. LaTorre the day following the treatment. He explained to the Board that the patient received atropine at 800mg. This dosage has a half life, according to the witness, of about sixty to ninety minutes. The half life is the same whether it is administered by way of IV or intramuscular. Concerning the issue of sending his brother to Philadelphia to obtain Physostigmine, Dr. Lopez clarified that he had two or three dosages in his office. He sent his brother to obtain an additional dosage after he was not able to locate any in a nearby pharmacy because he thought he might need an additional dose. Dr. Lopez admitted that he did not think to contact any of the hospitals in the vicinity in order to obtain the drug. After the initial dose, according to Dr. Lopez, CH appeared less confused. He believed that he also administered Dantrolene (1mg per kilo) every four hours and after the second dosage he noted that the blood pressure, temperature, and heart rate had all decreased. He ultimately concluded that CH suffered hyperthermia. He explained that he did not call an ambulance for an immediate transfer because he had treated this condition in the past. Additionally, after he began treatments, the patient began to improve. Dr. Lopez further recalled that he drove CH from his office in Elizabeth to Englewood Hospital, passing by numerous hospitals on the way. During the transport, he was the only person in the car and he did not have any other healthcare provider in the vehicle. According to his recollection, the only monitoring equipment in the car was a blood pressure machine. Dr. Lopez explained that he drove the patient the distance because he personally knew Dr. LaTorre and trusted him as a skilled intern. As Dr. Lopez recalled, he spoke with Dr. LaTorre prior to the transport and after they had arrived at the hospital. He believed that he informed Dr. LaTorre that he was transporting the patient and the length of time that the patient had been in the office. He did recall that Dr. LaTorre questioned him about keeping the patient in the office more than twenty-four hours, that he was running his office as an ICU, and why medication was not administered to attempt to reverse the adverse reaction. Dr. Lopez, however, did not believe that these questions were admonishments in particular because the patient was stable and only a bit confused, which he believed was secondary to being hypertensive. At the time of his transport of CH, she had appropriate motor responses, was alert, and was able to grasp his hand.

D.A.G. Bey-Lawson also reviewed the Order of Temporary Suspension dated August 28, 2002 with Dr. Lopez. He acknowledged that the Order prohibited him from practicing medicine in New Jersey and all other jurisdictions, foreign and domestic. Dr. Lopez further acknowledged that he did see patients out of his Queens, New York office. He explained that he had no other option since the patients were not able to secure appointments with any other physician. Dr. Lopez opined that because of all the media attention that his case has received, the doctors were fearful to take on his patients.

Dr. Lopez also admitted that he listed his practice specialty as "general practice" on his malpractice insurance application. He told the Board that he listed it in this way because he is not board certified in plastic surgery and therefore, did not list it as his specialty. His malpractice coverage was terminated because of his failure to pay the premiums. As he recalled, he learned of this when his office manager told him that she did not recall receiving a bill. When further inquiry was made, he learned that his policy had been terminated.

When questioned concerning hospital privileges, Dr. Lopez testified that he does not hold privileges at any hospital. Sometime between 1993 to 1995, he was an assisting attending for surgical dermatopathology, but never really had any direct patient care. He left the hospital on his own and returned to Columbia, South America to train in plastic surgery, which lasted about six months.

D.A.G. Bey-Lawson further pressed Dr. Lopez on his treatment of RR. As Dr. Lopez recalled, he administered 1 gram reserpine (IV) to the patient because there was a mild, superficial infection. He kept the patient for about an hour postoperatively and wanted to see the patient in three days for follow-up. Dr. Lopez was certain that he informed the patient's family that if complications present, he should immediately go to Saint Joseph's Hospital. He will use the antibiotic, along with oral quinalone, to reinforce the healing. Dr. Lopez obfuscated concerning risk factors for RR, however, he did state that RR was a healthy, twenty-three year old, obese patient with no significant medical history. He did not seek a medical clearance for RR because he was only using local anesthesia. If he had elected to use a general anesthesia, he might have sought a medical clearance.

Dr. Lopez also addressed questions about WN, the patient who had expired. As he recalled, he administered a modified LaTrenta solution of lidocaine (29.4 mg per kilo), which was injected into a fatty tissue area. There really was not an issue about toxicity in this patient, according to Dr. Lopez, because of the site injection. Additionally, he used the lidocaine in conjunction with epinephrine.

In closing, D.A.G. Bey-Lawson urged the Board to conclude that the evidence presented by the Attorney General demonstrated that Dr. Lopez posed an imminent danger to the health, safety and welfare of the citizens of New Jersey. She emphasized the treatment of CH was an example of the danger that Dr. Lopez presents. D.A.G. Bey-Lawson reviewed the facts as demonstrated from the patient records admitted into evidence and argued that the Board had more than a palpable showing of the danger that he presents to his patients. Finally, she reminded the Board that the testimony by Dr. Lopez did not refute the facts that are in the records. She requested that the Board reach the same conclusion as the State's expert, namely, that Dr. Lopez has engaged in gross negligence and repeated acts of negligence in his medical care of these patients. She submitted that the Board, based on the evidence and testimony presented, had more than ample grounds to grant the Attorney General's application for the continued suspension of Dr. Lopez' license to practice medicine and surgery in this State.

Mr. Bernhard asked that the Board pay close attention to the literature which was presented. In reviewing it, he was sure the Board would conclude that the State's expert based his opinion on an outdated standard. As such, the expert opinion should not be relied upon by the Board. He urged the Board, based on the literature, to conclude that Dr. Lopez did not present a danger to his patients.

Additionally, Mr. Bernhard argued that the testimony and issues raised during the hearing demonstrated the complexities of the case. These complexities, according to Mr. Bernhard, should mandate that the case should be tried in a full plenary hearing. He concluded by asking the Board to lift the temporary suspension previously agreed to by Dr. Lopez pending the full hearing since it continues to cause irreparable harm to him.

The Board, upon motion made and seconded, voted to go into executive session for deliberations. Deputies, other than counseling staff, left the room, along with all other members of the public.

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

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO CONTINUE THE TEMPORARY SUSPENSION OF DR. LOPEZ' LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY. THIS DECISION WAS BASED ON THE FOLLOWING FACTORS: THE CARE AND TREATMENT AFFORDED THE SIX PATIENTS DEMONSTRATE THAT DR. LOPEZ PRESENTS A CLEAR AND IMMINENT DANGER TO THE HEALTH, SAFETY AND WELFARE OF THE CITIZENS OF NEW JERSEY. ACCORDING TO THE EVIDENCE AND TESTIMONY PRESENTED, DR. LOPEZ IS NOT ABLE TO RECOGNIZE AN EMERGENCY, INAPPROPRIATELY MANAGES EMERGENCY SITUATIONS AND HAS POOR JUDGMENT IN SEVERE, EMERGENT SITUATIONS. DR. LOPEZ HAS FAILED TO ABIDE BY PRIOR BOARD ORDERS. DR. LOPEZ HAS NOT DEMONSTRATED SUFFICIENT, BASIC MEDICAL KNOWLEDGE, FAILED TO RECOGNIZE RISK FACTORS PRIOR TO SURGERY AND FAILED TO OPERATE ON APPROPRIATE CANDIDATES. DR. LOPEZ HAS FAILED TO ABIDE BY THE ANESTHESIA REGULATIONS AND HAS INADEQUATE SUPPORT STAFF TO ASSIST DURING SURGERIES. DR. LOPEZ ALSO EXHIBITED A LACK OF INTEGRITY INsofar AS HE HAS MISREPRESENTED THE TYPE OF SERVICES HE PERFORMED ON HIS MALPRACTICE INSURANCE APPLICATION FORM.

**2:30 p.m. - GOLDSTEIN, Jerrold, D.O. (Counseling Deputy: DICK)  
GORRELL, Joseph Esq., for Respondent  
KEOSKEY, Alex, D.A.G., for Complainant**

Order to Show Cause and Verified Complaint filed September 3, 2002 for the emergent temporary suspension of Dr. Goldstein's license based on allegations of dishonesty, fraud, deception and misrepresentation; indiscriminate prescribing of C.D.S.; gross malpractice, gross negligence, or gross incompetence and repeated acts of negligence, malpractice or incompetence; professional misconduct; violation of the recordkeeping requirements;

actions that demonstrate that Respondent's practice poses a clear and imminent danger to the public health, safety and welfare; demonstration of repeated deviations from appropriate standards of medical practice; and violation of Board regulations regarding dispensing of prescription medication.

The filed documents were provided to the Board under separate cover by the Division of Law.

Due to scheduling difficulties, the Board adjourned the matter. Although under protest by Mr. Gorrell, all parties agreed to the adjournment.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO ADJOURN THE HEARING UNTIL SEPTEMBER 25, 2002 BEFORE A COMMITTEE OF THE BOARD. THE BOARD FURTHER VOTED THAT THE COMMITTEE'S DECISION OF THE MATTER WOULD BE EFFECTIVE ON THE DAY THAT IT IS MADE, SUBJECT TO FULL BOARD CONSIDERATION FOR ACCEPTANCE, MODIFICATION, OR REJECTION OF THAT DECISION. Dr. Perry recused from discussion and vote in this matter and left the table.

## **OLD BUSINESS**

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

This matter was tabled from the Board's August 14, 2002 meeting so that the Division of Law could review the recent Supreme Court decision in Matter of Fanelli prior to the Board deciding whether to finalize this Provisional Order of Discipline (POD). The matter is now returned to the Board. The 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 GRANT DR. GANTI A MITIGATION HEARING BEFORE A COMMITTEE OF THE BOARD.

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

Enclosed are the Order of Temporary Suspension filed July 12, 2002 in the matter of Dr. Almahayni; Dr. Almahayni's July 21, 2002 letter addressed to Board President Harrer wherein she requests two changes in the Order that was served upon her, and D.A.G. Warhaftig's September 5, 2002 response taking no position to Dr. Almahayni's application for revision of the Board's Order. Dr. Almahayni's letter and the transcript of the hearing were both reviewed by Deputy Attorneys General Dick and Warhaftig. D.A.G. Dick believed it would be appropriate for the Board to consider whether the two changes requested by Dr. Almahayni should be made.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO GRANT THE REQUESTED CHANGES.

### **3. BURSZTYN, Enrique M., License #36989 FRIEDMAN, Arthur S., Esq., for Respondent PHAM, Jacqueline, D.A.G.**

A Provisional Order of Discipline (POD) was filed July 26, 2002 which would reprimand the above physician. Enclosed for Board consideration are D.A.G. Pham's August 12, 2002 letter to the Board, Mr. Friedman's August

14, 2002 response, and the POD with attachments filed July 26, 2002.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE THE MATTER AS A REPRIMAND.

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

This matter was tabled from the Board's August 14, 2002 meeting so that the Division of Law could review the recent Supreme Court decision in the Matter of Fanelli prior to the Board deciding whether to finalize this Provisional Order of Discipline (POD). The 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.

Also enclosed is Mr. LaBue's August 9, 2002 letter in response to D.A.G. Pham's July 23, 2002 letter in which she opposes Dr. Naseeruddin's request that the Board issue Dr. Naseeruddin a limited license to allow him to practice medicine at a federal facility such as the Veterans Affairs Hospital in Oregon. In addition, enclosed is Mr. LaBue's August 19, 2002 letter outlining the Supreme Court Decision in the matter of Dr. Fanelli indicating that he would like to be advised when a hearing will be scheduled in this matter.

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO GRANT DR. NASEERUDDIN A MITIGATION HEARING BEFORE A COMMITTEE OF THE BOARD.

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

This matter was tabled from the Board's August 14, 2002 meeting so that the Division of Law could review the recent Supreme Court decision in the Matter of Fanelli prior to the Board deciding whether to finalize this Provisional Order of Discipline (POD). The 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 FINALIZE THE ORDER MIRRORING THE DISCIPLINE IMPOSED BY NEW YORK.

**6. FINALIZATION OF PROVISIONAL ORDER OF DISCIPLINE**  
**I/M/O GALIN, Miles, M.D.**  
**ALBERTSON, B. Michelle, D.A.G.**

An Amended POD was filed September 19, 2001 which would revoke the above physician's license. The POD was sent to Dr. Galin's attorney. This matter was subject to finalization 30 days after issuance and no response was received. The Board, at its December 12, 2001 meeting, reviewed Executive Director Roeder's November 13,

2001 Affidavit with attachments and directed the Administrative Office to resend the POD to Dr. Galin instead of his attorney. Enclosed is Executive Director Roeder's recent Affidavit concerning the service of the POD to both the doctor and his attorney. No response has been received to date. The Attorney General again seeks the entry of a Final Order of Discipline without modification.

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

## **7. FINALIZATION OF PROVISIONAL ORDERS OF DISCIPLINE**

### **PHAM, Jacqueline, D.A.G.**

D.A.G. Pham has submitted the enclosed August 22, 2002 letter to the Board concerning Provisional Orders of Discipline (PODs) filed with respect to each of the six physicians listed below. Each matter was subject to finalization 30 days after issuance and no responses have been received. The Attorney General seeks the entry of Final Orders of Discipline without modification for each of the physicians listed below. Please note that Paul Noble, M.D., did respond to the POD and his name has been taken off this list. He will be listed on the Board's October 9, 2002 Agenda.

#### **1. ADAMOVICH, Jody, PA**

The POD was filed January 28, 2002 which would suspend the above physician's license for three years, to be served as probation. Enclosed is Executive Director Roeder's Affidavit with attachments.

#### **2. SNYDER, Richard, M.D.**

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

#### **3. SCHNEIDER, Howard, M.D.**

The POD was filed January 15, 2002 which would suspend the above physician's license for three years, retroactive to the date on which the suspension became effective in New York, two of which years are stayed to be probation. Enclosed is Executive Director Roeder's Affidavit with attachments.

#### **4. JAGDALE, Balkrishna, M.D.**

The POD was filed January 24, 2002 which would revoke the above physician's license. Enclosed is Executive Director Roeder's Affidavit with attachments.

#### **5. AVILA, Fred, M.D.**

The POD was filed January 30, 2002 which would place the above physician's license on probation for one year and require him to attend CME courses in proper office management and billing procedure and require him to submit documentation of completion of said courses before resuming practice in New Jersey. Enclosed is Executive Director Roeder's Affidavit with attachments.

#### **6. GEORGIA, Edward, M.D.**

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

THE BOARD, UPON MOTION MADE AND SECONDED, VOTED TO FINALIZE WITHOUT MODIFICATION THESE MATTERS.

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,

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

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