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NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

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

In the matter of:

ANCA POPA, M.D.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon receipt of a report from the Medical Practitioner Review Panel (the "Panel"), detailing findings and recommendations made following the Panel's investigation of information reported by Palisades Medical Center ("Palisades") regarding actions taken against respondent Anca Popa, M.D. at Palisades. Specifically, on September 5, 2013, Palisades reported: 1) that on or about August 30, 2013, Dr. Popa was asked to, and then did, resign her position as Chair of the Department of Orthopedics; 2) that she was removed from the emergency department call schedule; and 3) that the timeliness of her responses to requests for consultations was subject to monitoring by the Chief Medical Officer of the Hospital for a period of six months. Dr. Popa complied, was found to have responded appropriately during said six month period, and consequently the monitoring was terminated at its conclusion. Palisades' actions were taken at the conclusion of a hospital investigation focused upon the timeliness

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and appropriateness of Dr. Popa's care of patient J.S. on July 30 and 31, 2013. Palisades reported that its investigation revealed that Dr. Popa had delayed in responding to a request for consultation in J.S.' case and that her delay caused vascular injury to the patient, requiring multiple surgical interventions.

The Panel reviewed available information concerning this matter, to include a written adverse action report submitted by Palisades and accompanying documentation, the hospital chart for patient J.S. and testimony offered by respondent when she appeared before the Panel for an investigative hearing on April 24, 2015. Respondent is represented in this matter by Joseph M. Gorrell, Esq.

Upon completion of its investigation, the Panel found that respondent Anca Popa, M.D. was the "on call" orthopedic surgeon at Palisades on July 30, 2013. Patient J.S. presented to the emergency room at approximately 5:00 p.m., having been injured when he was struck by an automobile while skateboarding. X-rays revealed a femoral shaft fracture.

Dr. Popa was first called at approximately 6:00 p.m. She was then in the operating room at Palisades (supervising another orthopedist), but was able to view JS' x-rays by remote access. Dr. Popa admitted J.S. to her service, and requested that a pediatrician be called as a consultant to examine J.S. Dr. Popa left Palisades at approximately 8:30 p.m. on July 31, 2013, without examining J.S. When appearing before the Panel, she testified that

her plan at that time, after discussing the case with the consulting pediatrician, was to take J.S. to the operating room for surgery the following morning, at approximately 10:00 a.m.

During the course of the evening (July 30 - 31, 2013), Dr. Popa received several phone calls at home from the attending pediatrician and/or nurses at the hospital regarding patient J.S. While Dr. Popa testified that she did not recall specific details regarding those conversations, hospital records reflect that she was called, at approximately 10:00 p.m. on July 30, 2013, and advised that circulation in J.S.'s left foot had been found, on examination, to be impaired (documentation in J.S.' hospital chart includes findings of bluish, mottled toes, a cold left foot and weak movement of toes). At that time, respondent suggested that the ace wrap that was holding the splint on J.S.' leg should be cut, and Dr. Popa's request for a consult from the vascular surgeon was then cancelled. Thereafter, the records reflect that Dr. Popa received multiple additional phone calls regarding J.S.' vascular condition. During one such call, Dr. Popa was advised that a PGY 1 surgical resident had examined J.S., and that the resident had not felt that J.S. had a compartment syndrome. The hospital record also includes a note detailing that a nurse, acting at the pediatric attending physician's request, called Dr. Popa at 3:51 a.m. and advised her of findings including intermittent pedal pulses, numbness and coolness in the toes.

Dr. Popa testified that she first arrived at Palisades on July 31, 2013 between 9:30 a.m and 10:00 a.m., at which time neither an operating room nor the physician who she had planned to use as a first assistant was available. Hospital records suggest that Dr. Popa examined J.S. at 11:30 a.m. on July 31, 2013. Respondent's physical examination note documents findings of a weak pulse at left dorstalis, and her recorded impressions state: "fracture shaft left femur. Impending compartment syndrome left leg/calf." Although Dr. Popa could have then sought to use a pressure monitor to measure compartment pressure (i.e., to determine whether a compartment syndrome was present), she did not do so. When appearing before the Panel, Dr. Popa testified that she did not check compartment pressure when she first examined J.S. because she felt something else might have been impairing the patient's circulation. At approximately 2:30 p.m., because neither an operating room nor an assistant surgeon was available, Dr. Popa decided to transfer J.S. to Hackensack Hospital, and the hospital record details that J.S. was thereafter transferred at 4:00 p.m.

The Panel found that Dr. Popa engaged in two distinct acts of gross negligence when providing care to J.S. First, the Panel found that Dr. Popa's failure to examine J.S. for over seventeen hours -- from the time she initially was advised of his hospital admission at 6:00 p.m. on July 30, 2013 through the recorded time of her initial examination at 11:30 a.m. on July 31,

2013 - constituted gross negligence. Specifically, the Panel found that Dr. Popa was advised in the multiple calls that were placed to her that J.S. was exhibiting symptoms indicative of serious vascular compromise to his lower extremity, to include without limitation information regarding findings of decreased pulses and bluish toes. The Panel found that said information should have caused Dr. Popa to consider the possibility of a developing compartment syndrome, and necessitated a more timely examination to determine whether a surgical emergency existed.[1]

Additionally, the Panel found that Dr. Popa engaged in a second, independent act of gross negligence when she failed, at the time she conducted her initial examination of J.S. on July 31, 2013, to have measured compartment pressure to determine whether compartment syndrome was present. Given J.S.' presentation and the continuing unavailability of any operating room, the Panel found it was incumbent upon Dr. Popa to have then sought to measure compartment pressure, and to have made arrangements to perform an immediate fasciotomy (assuming that she would have then diagnosed a compartment syndrome).

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[1] When appearing before the Panel, Dr. Popa testified that she was advised by Dr. Moshet (the on call pediatrician) that a PGY 1 surgical resident had examined J.S. and that the resident did not feel there was a compartment syndrome. The Panel found that it was unreasonable for Dr. Popa to have relied solely on the findings made by a PGY 1 surgical resident, who would have then been in the first month of his or her residency, as that determination should instead have been made by a more experienced physician.

The Board herein adopts all of the above set forth findings made by the Panel, and concludes that grounds for disciplinary action against Dr. Popa therefore exist pursuant to N.J.S.A. 45:1-21 (c) and/or (d). Dr. Popa neither admits nor denies the findings made herein. The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board being satisfied that good cause exists for the entry of this Order,

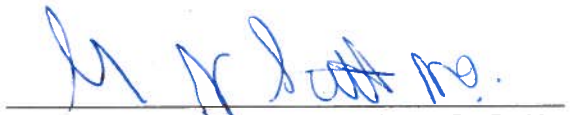
IT IS on this 25th day of February, 2016

ORDERED and AGREED:

1. Respondent Anca Popa, M.D., is hereby reprimanded for having engaged in two distinct acts of gross negligence when providing care to patient J.S., as more fully detailed above.

2. Respondent is assessed a civil penalty in the amount of $12,500, which penalty shall be payable in full within ten (10) days of the entry of this Order.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: 

George J. Scott, D.O., D.P.M.
Board Vice-President

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

Anca Popa, M.D.

Dated: 2.10.16

Consent to form of Order and to the entry of this Order by the Board.

Joseph M. Gorrell, Esq.
Counsel for Dr. Popa

Dated: 2/11/16

Feb 11 2016 5:05PM HP LASERJET FAX p.2

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

_____
Anca Popa, M.D.

Dated: _____

Consent to form of Order and to the entry of this Order by the Board.

_____
Joseph M. Gorrell, Esq.
Counsel for Dr. Popa

Dated: _____

NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

(1) Which revokes or suspends (or otherwise restricts) a license,
(2) Which censures, reprimands or places on probation,
(3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license(and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A.45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.