Office of Administrative Law
State of New Jersey

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF STEVEN CHASE BRIGHAM, M.D., TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY

Professional Boards

OAL Docket No. BDS 1303-94 and BDS 2468-95

Initial Decision: April 12, 1996
Final Agency Decision: August 28, 1996

INITIAL DECISION

AND

FINAL AGENCY DECISION

Linda S. Ershow-Levenberg, Deputy Attorney General, on behalf of complainant Attorney General of New Jersey (Deborah T. Poritz, Attorney General of New Jersey, attorney)

Nathan L. Dembin, Esq., member of the New York Bar, admitted pro hac vice, on behalf of respondent Steven Chase Brigham, M.D. Attorney of Record: Kenneth S. Javerbaum, Esq. (Javerbaum, Wurgaft & Hicks, attorneys)

FIDLER, ALJ:

STATEMENT OF THE CASE

This matter arises out of three complaints filed by the Attorney General of New Jersey ("complainant") with the State Board of Medical Examiners ("the Board") seeking sanctions against Steven Chase Brigham, M.D. ("respondent"), pursuant to N.J.S.A. 45:1-21. At issue in this matter is whether respondent committed the acts and violations alleged in the complaints, and if so, should his license to practice medicine and surgery in the State of New Jersey be suspended or revoked pursuant to N.J.S.A. 45:1-21, and should other penalties and costs be imposed. Also at issue is whether the revocation of respondent's license by the State of New York constitutes a revocation of medical licensure for reasons consistent with N.J.S.A. 45:1-21 and therefore constitutes grounds for disciplinary action against his medical license in New Jersey, pursuant to N.J.S.A. 45:1-21(g).

PROCEDURAL HISTORY

The first complaint was filed on November 24, 1993, and was subsequently amended ("Amended Complaint"). The respondent's answer to this complaint was filed on December 9, 1993. By Interim Decision and Order dated February 3, 1994, the Board placed certain restrictions on the respondent's practice, directing that he not initiate or participate in second trimester abortions, including the insertion of laminaria in patients for purposes of cervical dilation preceding evacuation of the uterus. The Board also ordered the appointment of an acceptable monitor. On February 10, 1994, the matter was transmitted to the Office of Administrative Law for determination as a contested case, pursuant to N.J.S.A. 52:14F-1 to -13. The second complaint was filed on July 5, 1994 ("Second Complaint"), and the respondent's answer was filed on July 20, 1994. Following an Order to Show Cause proceeding before the Board on August 1, 1994, the Board declined to place any further restrictions on respondent's practice pending a plenary hearing. Consolidation of the second complaint was confirmed at the telephone prehearing conference conducted on August 31, 1994.

On December 2, 1994, the complainant filed another complaint with the Board ("Third Complaint"), also seeking sanctions against the respondent, based upon the allegation that the respondent's license to practice medicine in the State of New York had been revoked by the New York State Department of Health Administrative Review Board for Professional Medical Conduct. By Order effective December 14, 1994, the Board accepted respondent's offer to cease practicing in New Jersey and declined to then impose revocation of respondent's license based on New York's action, pending the New Jersey administrative law proceeding. On March 9, 1995, the New Jersey Board also transmitted this complaint to the Office of Administrative Law for determination as a contested case. The complainant moved for consolidation with the earlier matters and also moved for partial summary decision and other relief. The respondent opposed the application and by cross-motion sought an order to dismiss the latest complaint. The motion for consolidation was granted on the record on May 26, 1995, pursuant to N.J.A.C. 1:1-17.3. However, ruling on the remainder of the motions was deferred until completion of the evidentiary record, based on the Board's ruling of December 14, 1994.

Hearing sessions were held at the Office of Administrative Law, in both Newark and Mercerville, New Jersey. There were 29 days of hearing, beginning October 24, 1994 and ending June 30, 1995. At the close of the hearing, counsel for complainant requested permission to submit an opinion letter from Dr. Hollander in rebuttal. Permission was granted, and the letter was admitted into evidence as Exhibit P-66. Complainant later objected to respondent's offer of additional opinion letters Exhibits R-67 and R-68, by Drs. Fogel and Burnhill, submitted as "surrebuttal" to the opinion letter of Dr. Hollander. However, the additional letters were useful and have been admitted into evidence. Complainant filed a post-hearing motion to correct the record to accurately and fully state a stipulation which had been read into the record during the hearing. The motion is unopposed and is granted.

The record also remained open following the hearing to permit submission of post-hearing briefs. The last of these was received on September 26, 1995, and the record closed on that date. The time limit for filing this Initial Decision was extended by Orders of Extension.

OPINION WITNESSES

Complainant's Experts

Nicholas Kotopolous, M.D. is a Board certified obstetrician/gynecologist and a fellow of the American College of Obstetrics and Gynecology. He has been the Medical Director of Metropolitan Medical Associates in Englewood, New Jersey, since 1980, with an active clinical practice in first and second trimester abortions. He has performed abortions numbering many thousands, including thousands of second trimester procedures over 18 weeks gestation. As a formal instructor for the Englewood Hospital residence program, Kotopolous has trained approximately 120 resident physicians, and he is the primary consultant for cases at the hospital involving termination of pregnancy. The State Board of Medical Examiners has authorized Kotopolous to perform abortions up to 24 weeks LMP, the legal limit in New Jersey. Dr. Kotopolous testified for the complainant as an expert and, in part, a fact witness, concerning patients J.K., A.W., Y.B., M.B., and D.V..

It should be noted here that respondent argues that the inevitable possibility of bias of a business competitor so taints and undermines Dr. Kotopolous' objectivity that his testimony can not be given great weight. Further, respondent contends that the Federal Health Care Quality Improvement Act mandates that Dr. Kotopolous' competition with Dr. Brigham disqualify him as a witness in this matter. Complainant contends Dr. Kotopolous was no less credible in this matter because some or all of Dr. Brigham's patients might go to Dr. Kotopolous' facility if Dr. Brigham were not practicing in New Jersey. There is ample evidence in the record to establish that Dr. Kotopolous and Dr. Brigham have shared at least a portion of the abortion patient pool, and could fairly be said to be in economic competition. Two patients (T.F. and D.V.) called the State to complain about Dr. Brigham while they were at Dr. Kotopolous' facility in Englewood.

David Hollander, M.D., is a Board certified obstetrician/gynecologist and has been engaged in an active clinical practice since 1980. His involvement in ob/gyn related committees includes hospital prenatal quality assurance, and he was Chief of the Division of Maternal-Fetal Medicine at St. Barnabas Medical Center in Livingston, New Jersey, from 1986 to 1991. Dr. Hollander has held teaching appointments including an assistant clinical professorship at the University of Medicine and Dentistry of New Jersey. He has performed second trimester abortions up to 24 weeks, all in a hospital setting, and he has dealt with complications from abortions performed by others up to 24 weeks. Since 1984, Dr. Hollander has performed between 120 and 140 second trimester abortions using the D&E method. He has done his own ultrasounds since 1986. Dr. Hollander testified as an expert witness for the complainant.

Respondent's Experts

Dr. Michael Policar, who is licensed to practice medicine in California, is Board certified in obstetrics and gynecology and has been Fellow of Obstetrics and Gynecology since 1984. He served on the faculty of the University of California, Los Angeles and San Francisco Schools of Medicine. He is currently an Assistant Clinical Professor of Obstetrics and Gynecology at the University of San Francisco. For twelve years, Dr. Policar has taught first and second trimester abortion procedures, primarily to ob/gyn residents. He has also lectured extensively on abortion topics to practitioners and at medical schools, as well as periodic meetings of the National Abortion Federation. He has served on the board of advisors of that organization and was an ex officio member of its Board of Directors for three years, while he served as the Vice President for Medical Affairs of Planned Parenthood.

Dr. Policar is familiar with the National Abortion Federation medical standards of practice and has been involved with formulating their updates and revisions. He has also been national spokesperson for the National Office of Planned Parenthood and as Vice President for Medical Affairs of Planned Parenthood, he was responsible for drafting National Planned Parenthood standards and procedures for performing abortions that apply to all Planned Parenthood affiliates. Dr. Policar has co-authored a curriculum on abortion practice for the National Abortion Federation, and he wrote two chapters of Precis of the American College of Obstetrics and Gynecology.

Dr. Jeffrey Moskowitz is licensed to practice medicine in the State of New York. He is a graduate of Yale University and Toronto Medical School. Dr. Moskowitz is a Board certified obstetrician/gynecologist, with privileges at Lenox Hill Hospital. In February 1991 he became medical director and administrator of Eastern Women's Center, specializing in terminations of pregnancies from 5 weeks to 24 weeks. Dr. Moskowitz believes that Eastern is the largest provider of abortion services in the United States, performing approximately 20 thousand procedures in a year. Among his duties is evaluation of all physicians at Eastern, and he chairs the quality assurance committee. Dr. Moskowitz is familiar with the standards of medical practice.

Dr. Michael Burnhill is licensed to practice medicine in several states, including New Jersey and New York. He is a Board certified obstetrician/gynecologist and is a fellow of the American College of Obstetricians & Gynecologists and the Society of Reproductive Medicine. Dr. Burnhill is a member of the Society of Reproductive Health Professionals, the National Abortion Federation, the American College of OB/GYN and the New York Obstetrical Society (Exhibit R-60).

Dr. Burnhill has long been involved in the provision of abortions. He has been a member of the Association of Planned Parenthood Physicians since 1965, and in 1970 he became the liaison member to the National Committee of Planned Parenthood. In 1972 he became the Director of the Margaret Sanger Center in New York City. Dr. Burnhill was Chair of the standards implementation committee of the National Abortion Federation for four years and he has chaired and participated in postgraduate seminars dealing with quality control, risk management, detection,

prevention and treatment of complications. He has served on the faculty of the Downstate Medical Center since 1965, and has been a Clinical Associate Professor at Cornell Medical Center and at the George Washington Medical Center. Dr. Burnhill also was an Associate Professor at Johns Hopkins University and he has served since 1979 as Professor at Robert Wood Johnson Medical Center in New Brunswick, New Jersey.

Dr. Burnhill has served as the Vice President of the National Abortion Federation and has been on that organization's board of advisors for ten years. He has annually presented lectures to the National Abortion Federation and Planned Parenthood for about twenty years. Dr. Burnhill has also lectured extensively elsewhere annually and has published numerous articles in peer review journals on abortion topics. According to Dr. Burnhill, there are two current published standards for abortion procedures: the Manual of the National Abortion Federation and the Standards and Guidelines of the Planned Parenthood Federation.

William Henry Knorr, M.D. is a Board Certified OB/GYN and Fellow of the American College of Obstetrics and Gynecology. He maintains privileges at three hospitals. Dr. Knorr began performing abortions immediately after his residency in 1984, and has personally performed approximately 30,000 abortions over the last ten years. He has performed greater than 1,000 second trimester abortion procedures.

M.A.B., M.D., is presently actively engaged in providing abortions. He obtained his medical education in England, Germany, Canada and the United States. He has attending privileges at Beth Israel Hospital in New York and St. Agnes Hospital in Westchester and is also a clinical instructor at Mt. Sinai. He is a member of the American College of Obstetricians and Gynecologists, to which he has presented papers, and the American Fertility Society. Dr. M.A.B. has performed approximately 8,000 termination of pregnancy procedures, and approximately 800 of those have been dilation and evacuation procedures. Dr. M.A.B. served as an owner and president of Queens OB-GYN Services.

Anthony Mustalish, M.D., graduated Phi Beta Kappa from New York University in 1962 and then from New York University School of Medicine. He served in two field hospitals in Vietnam in 1969 and 1970, where more than one-half of his patients were wounded soldiers who had suffered traumatic injuries causing profound blood loss and shock. He also received a masters in Public Health from Harvard School of Public Health. Dr. Mustalish became Board Certified in Preventive Medicine and was appointed Deputy Commissioner of Health in the City of New York, serving until 1977. He is also Board Certified in Emergency Medicine, and is recognized as a Diplomat and specialist in emergency medicine. He is also certified in a number of other specialized areas of emergency medicine including advanced trauma life support, advanced cardiac life support, and basic life support.

Dr. Mustalish served as the Chief of the Emergency Department at Brookdale Hospital in New York, where he saw approximately 100,000 patients a year. Dr. Mustalish has also served as Senior Vice President for Operations and Chief Operating Officer at Lenox Hill Hospital and was Chief of the Emergency Room Department. He established standards of care and practice, developed policies and procedures, and provided quality assurance. As Chief Operating Officer, Dr. Mustalish was responsible for quality assurance throughout the entire hospital. In the 1980's, Dr. Mustalish became the first chairman for the Standards Committee in New York, creating statewide standards for emergency care practice. Dr. Mustalish was also the director of the ambulance service at Lenox Hill Hospital, where he expanded the program and set up the first paramedic program. He was also part of the Medic Advisory Committee for EMS in the City of New York and was on the faculty of the EMS academy, providing training, teaching, certification and re-certification of New York paramedics.

Since 1990, Dr. Mustalish has been an assistant professor of Emergency Medicine in Public Health and has been fulfilling dual appointments at the Cornell University Medical College while he serves as an attending physician in the Emergency Department at New York Hospital. He has testified before legislative hearings and council hearing concerning standards for emergency medical services and he has been

recognized as an expert in several state courts. Dr. Mustalish has cared for many patients following abortions who have had emergency complications, including bleeding and cervical lacerations.

Narda Johnson has been a diagnostic ultrasound technician or sonographer since 1983. She has been certified as a sonographer since 1984. Ms. Johnson completed a one year course with Ultrasound Diagnostic School, continued her education at New York University and took courses at Yale on High Risk Obstetrics. She has worked at Greenwich Hospital and Wilson Memorial Hospital in North Carolina. In private practice, she reviews cases with radiologists. Ms. Johnson performs level two ultrasounds and does multiple measurements for gestational age. 90 percent of Ms. Johnson's sonographer work involves obstetrics, estimating gestational age.

A.K., D.O., is an obstetrician/gynecologist who was approved by the Board to monitor Respondent. He has performed over ten thousand late second trimester termination of pregnancy procedures. Linda Ball has been a licensed Registered Nurse since 1968 and is one of the first certified as a Women's Health Care Nurse Practitioner. She received her training at Englewood Hospital School of Nursing and achieved a Masters in community health education. Ms. Ball also participated in the ambassadorship program in women's health in China.

Ms. Ball was Clinic Supervisor of a Planned Parenthood location, and she also served as Associate Executive Director to Planned Parenthood, overseeing the day to day operation of four locations. She has served as Head Nurse, Nurse Practitioner, and administrator of an abortion facility for approximately eight years. Ms. Ball has participated in approximately 5,000 first trimester procedures and approximately 1,000 second trimester procedures.

Tiberious Dengelegi, M.D., submitted an affidavit on behalf of Dr. Brigham. He has been practicing obstetrics/gynecology for more than 30 years, and he worked with Dr. Brigham. Dr. Kotopolous testified that he knows Dr. Dengelegi and has a high regard for him as a physician. Dr. Kotopolous personally observed Dr. Dengelegi while he was operating at Eastern Women's Center, and he believes that Dr. Dengelegi is well recognized and experienced in abortions, and is Board certified in Obstetrics/Gynecology.

Philip Stubblefield, M.D., submitted an affidavit on behalf of Dr. Brigham (Exhibit P-57). He is currently Chairman of the Department of Obstetrics and Gynecology at Boston University Medical School. Dr. Stubblefield has personally performed, and taught Ob/Gyn residents how to perform, thousands of abortion procedures. He is widely known in the field of abortion and the author of many published articles on that topic. Dr. Stubblefield is also the author of the "Pregnancy Termination" section of the American College of Obstetrics and Gynecology's Precis V.

Marvin Fogel, M.D., also submitted an affidavit on behalf of Dr. Brigham. This obstetrics/gynecology practitioner is former Dean of Mount Sinai Medical School, Director of Quality Assurance of Mt. Sinai Medical Center, and Professor of Obstetrics and Gynecology. Charles H. Debrovner, M.D., also submitted an affidavit on behalf of Dr. Brigham. He has been a Board Certified Ob/Gyn since 1968 and is an attending physician at four major New York metropolitan hospitals. He has lectured and authored extensively in the field of obstetrics/gynecology.

Anthony M. Vintzileos, M.D., submitted an affidavit on respondent's behalf (Exhibit R-40). He is presently Professor of Obstetrics and Gynecology and Director of the Division of Maternal/Fetal Medicine at Robert Wood Johnson Medical School. Dr. Vintzileos is a fellow of the American College of Obstetricians and Gynecologists. He has published scientific papers on the subject of obstetrical ultrasound.

Steven Chase Brigham, M.D., was graduated from MIT in 1978, and from Columbia Medical School in 1986. His training in medical school included clinical emergency room rotation for two months. He then performed a one year internship in internal medicine at Westchester Medical Center, which included several weeks of emergency

room rotation. He had part-time positions in emergency rooms and a walk-in clinic.

Brigham's experience also includes emergency room service at Keller Hospital at the United States Military Academy for one to three shifts per week and one or two shifts per week at Ellenville Hospital. He also worked some shifts at West Point during the Persian Gulf War. In addition, he had a short period of service at an urgi-center in Fair Lawn, New Jersey. Brigham estimated that he has treated several thousand patients in emergency rooms. After his internship and about two years of practice in New York State, Brigham opened a practice in the State of Pennsylvania. He did some house calls and participated in a wellness program for children, and he also performed some abortions, which he found rewarding, primarily because he was helping women.

Brigham's post-graduate training in abortion and gynecology was attained primarily through attendance at numerous medical education symposia, through observation of experienced practitioners, and through some programs involving hands-on experience under supervision. He considers the National Abortion Federation to be a vital source of information on abortion techniques. He described the Federation as a voluntary association of abortion providers set up to provide high quality medical care through dissemination of information. Brigham had no ob/gyn residency, and he is not Board certified in ob/gyn, but he noted that the same is true for many prominent practitioners in the abortion field. According to Brigham, most ob/gyn residency training does not include training in performing abortions, and it was his opinion that the American College of Ob/Gyn has almost abdicated its role concerning abortion related matters, even though abortions are the most common surgical procedure.

Beginning in 1990 or 1991, Brigham was primarily engaged in the medical practice of performing abortions. In the State of Pennsylvania, he performed abortions at two different office locations and at a clinic in Harrisburg, and he estimated that he performed between two and four thousand abortions. Brigham faced overt hostility in Pennsylvania because of his abortion practice and he eventually decided he could no longer practice there. In April 1992, Brigham closed his practice in Pennsylvania and signed a Consent Agreement to permanently retire his Pennsylvania license. No evidence was presented in this matter to establish any improprieties in Pennsylvania, and no charges were ever filed against Brigham in that state.

Dr. Brigham estimated that he has performed about fifteen thousand first trimester abortions. Of these, eight or nine thousand have been performed in New Jersey. Without complications, a first trimester abortion takes three or four minutes and involves no cutting of tissue or suturing. When there in no use of general anesthesia, intraoperative vital signs would not be monitored, according to Dr. Brigham, because the procedure is so brief. He noted that anesthesiologists only monitor vital signs every five minutes.

Brigham numbered his second trimester abortions at over one thousand. Using what he called the classical D&E procedure, adequate dilatation is first achieved by inserting laminaria, and fetal demise would be induce by an injection of digoxin. The fetus is easier to dismember when it is dead. Because less force is necessary, there is less risk of harming the patient. When dilatation is adequate, the demised fetus is grasped with an instrument, dismembered, and removed from the uterus piece by piece. While Brigham prefers to remove the placenta first, that is not always possible. He acknowledged that the potential for uterine perforation is greater with a second trimester abortion, and he stated that he knew of no abortion practitioner who has never had a perforation of any kind. It was Brigham's testimony that out of all the first and second trimester abortions he has performed, he was aware of significant complications only in the A.W. and M.B. cases.

The Case of J.K. (Amended Complaint, Count I)

Complainant alleges that respondent Brigham's conduct concerning patient J.K. constitutes gross or repeated acts of negligence, malpractice or incompetence, as

well as professional misconduct, and that he exhibited poor judgment which calls into question his ability to safely practice medicine in this State. Complainant further asserts that respondent's conduct therefore constitutes grounds pursuant to N.J.S.A. 45:9-16 and 45:1-21(c), (d), (e) and (h) for the revocation or suspension of his license to practice medicine and surgery in this State.

At the completion of the Complainant's case in chief, some of the allegations in this count of the first amended Complaint were dismissed for failure to establish a prima facie case. The remaining allegations concerning the time J.K. was in respondent's care are that:

1. By inserting laminaria in J.K., respondent violated N.J.A.C. 13:35-4.2, which restricts the performance of second trimester abortions to licensed ambulatory facilities and hospitals, and further restricts the performance of abortions past 20 weeks LMP to specified circumstances with the specific approval of the Board;
2. Respondent's management plan for J.K. was a gross deviation from generally accepted standards for a two day termination of late stage pregnancy, in that he inserted the laminaria in a patient who had to travel over an hour to and from his office each day and he further intended to transport her an additional two hours to the clinic in New York for the actual completion of the procedure;
3. Respondent's conduct subjected J.K. to enhanced risk of hemorrhage and infection and all risks which flow from that.

The findings of fact which follow are derived from the credible evidence in the record. J.K. was 24 weeks pregnant when she sought an abortion at All Women's Medical Pavilion in Queens, New York on July 2, 1992. Ultrasound confirmed fetal heartbeat and a 24 week gestation (Exhibit R-18). She could not afford to have the abortion there. She testified that she did not meet respondent that day and someone just mentioned his name to her as a doctor who might help her with the financial problem of having a 24 week abortion at an affordable cost.

J.K. lived over 50 miles away from respondent's Voorhees office. She called there and was subsequently examined by respondent on July 14, 1992. She was 5'9 " tall and weighed 105 pounds. No fetal heartbeat was detected and respondent's conclusion was that there was a fetal demise. J.K. did not want to have to have an induced-labor type abortion. Respondent explained that he would insert laminaria to dilate her cervix for two days and on the third day he would do the abortion at the Queens facility where she would be his private patient and he could charge her a lower fee. He inserted 8 laminaria, four large and four small. He prescribed doxycycline, and discharged J.K. to return the next day. She rode away on the back of a motorcycle.

The next day, J.K. came back to respondent's office. Her cervix was already dilated to 2.4 centimeters. Dr. Brigham removed the laminaria and her membranes spontaneously ruptured. At the point, respondent believed that J.K. was at a higher risk for infection. Nevertheless, respondent stayed with his plan. He inserted 22 fresh laminaria, still planning to complete the abortion the next day in Queens. It is undisputed that Dr. Brigham did not telephone his local backup physician on the first day or second day, nor did not refer J.K. to a hospital or to a licensed ambulatory care clinic or to any other practitioner on the second day for completion of the abortion at that time. He did not suggest to J.K. that they go to Queens that afternoon or evening to complete the abortion.

J.K. again went home on a motorcycle. The patient called him at 7:00 p.m. reporting a 102 degree fever and cramps. She informed him that she had not taken the antibiotics. Respondent did not contact his local backup physician, and at that time, he did not refer J.K. to her local hospital's emergency room. Instead, he called in a prescription to J.K.'s pharmacy and told her to call him again.

At 8:00 p.m. respondent called J.K., who told him that she was feeling better; he told her to call him if things got worse. When she called again at 11:00 reporting a fever of 102.7 degrees, slow bleeding from her vagina and contractions four to five minutes apart, he told her to go to the nearest emergency room. Respondent called that hospital and spoke with the charge nurse and the chief resident. The examining doctors, Dr. Hamley and Dr. Houlihan, were of the view that she had

clinical chorioamnitis, an infectious process (P-1A), a clinical assessment with which Dr. Burnhill, who was Chief of the Ob-Gyn Department at Robert Wood Johnson at that time, had no quarrel as an initial, presumptive diagnosis. However, this diagnosis was not born out by pathological confirmation or through positive microbiological identification.

J.K. was admitted to labor and delivery. She received intravenous pain medication and antibiotics. She labored until 5:00 a.m., at which point the dead fetus was delivered and shown to her by the apparently unsympathetic staff. J.K. testified that she was extremely distressed and angry over the course of events, but she fortunately suffered no additional untoward physical results.

It was the opinion of Dr. Kotopolous that Dr. Brigham should have diagnosed the condition of 24 weeks' pregnancy with intrauterine fetal demise, and then referred J.K. to a hospital where the abortion procedure could be performed and attendant risks and complications addressed. Dr. Kotopolous opined that fetal demise can subject a patient to risks of spontaneous disseminated intravascular coagulopathy ("D.I.C."), a clotting disorder. He also was concerned that with a patient such as J.K., a severe infection could develop within 24 hours or less. In Dr. Kotopolous' opinion, these complications could not be handled on an outpatient basis.

Unlike Dr. Kotopolous, the complainant's other expert, Dr. Hollander, did not find fault with respondent's management of J.K. on the first day. Rather, his concern was with the insertion of additional laminaria on the second day, after the patient's membranes had ruptured and she was dilated at 2.4 centimeters. He opined that Dr. Brigham should have promptly referred J.K. to the nearest hospital or other facility or to another physician for completion of the procedure. There was adequate minimal dilatation according to the standards articulated even by some of the respondent's experts. Since complainant himself believed J.K. to be at a higher risk of infection in light of her ruptured membranes, he could have taken her to New York on the second day to complete the procedure. Both Dr. Hollander and Dr. Kotopolous felt that it was a gross deviation from the generally accepted standards of care for Dr. Brigham not to have chosen one of the alternatives available to him and to instead stay with his original plan of treatment.

Dr. Brigham testified that J.K. was extremely thin and gaunt looking, and she seemed anxious and depressed. Based on his pelvic exam, he felt she was at 22 to 24 weeks, and the sonogram revealed, among other things, a femur length equating to 23 weeks, 3 days. After reviewing the mylar sonography images and a real-time sonogram, Dr. Brigham concluded that the fetal demise was no more than four days earlier. He noted that Dr. Hollander had no disagreement with his handling of J.K. on the first visit. It was a recent fetal demise, so clotting factors were not an issue, and although he did not consider it definitive, he actually observed her blood clotting. Further, it was appropriate to insert laminaria to obtain adequate cervical dilatation. He disagreed with Dr. Kotopolous' opinion that J.K. needed to be transferred to a hospital on the first day. Dr. Brigham suggested to J.K. that she stay in a nearby motel after insertion of the laminaria, but she said she could not afford it. He gave her enough antibiotics to last several days.

Dr. Brigham testified that when J.K. returned the next day, he removed the laminaria. Within seconds, the patient's bulging membranes ruptured. He drained the amniotic fluid that came out of her uterus and cervix, and inserted more laminaria. According to Dr. Brigham, if there was adequate dilatation at that time, he and the patient would have gone to New York and he would have done the abortion, but he did not think she was adequately dilated. He suggested that J.K. go to the hospital because of her fragile mental state and because he was under the impression there was an increased risk of infection from the ruptured membrane. Dr. Brigham testified that he was surprised to learn that Dr. Moskowitz's data indicates there is no increased risk. However, J.K. refused to go to the hospital, telling the doctor that she could not afford it. The abortion procedure was to be done the next morning in New York. When Dr. Brigham saw J.K. getting ready to leave on the back of a motorcycle, he ran out and pleaded with her not to ride it, and he offered her money for the train. J.K. declined, saying she would be all right.

Dr. Brigham noted that it is normal in the abortion provision field that patients come from all over and often travel large distances between home and the doctor's office. He had back up arrangements with two ob/gyns with hospital admitting privileges in the Voorhees area, but he could not possibly have back up arrangements at hundreds of hospitals in several states from which his patients came. He knew that J.K. lived within walking distance of Robert Wood Johnson Hospital, and he felt she would not be denied emergency care if she needed it. In addition, he was going to be evacuating her uterus in less than 24 hours, and he had given her antibiotics.

That evening, J.K. called Dr. Brigham and told him she had cramping and fever, and she admitted that she had not taken the antibiotics. He called in a prescription for a stronger antibiotic to her pharmacy, and told her to take it. About an hour later, J.K. called back and told Dr. Brigham that she had no fever and a little cramping. She was taking the new drug. However, later that night there was another call. J.K. reported that the fever was back, there was slow bleeding, and there were contractions every five minutes. She wanted to know if she could get on the motorcycle and come to Dr. Brigham's office, about 50 miles away. He testified that he told her that was not a good idea, and she should go to the hospital, not on the motorcycle but in a car or ambulance. He told her he would call there and let them know the information they would need.

Dr. Brigham called the emergency room and explained the patient history to the doctor in charge. The emergency room doctor said he was just going to send J.K. up to labor and delivery. Dr. Brigham left his name and phone number so he could be contacted. He felt his efforts constituted prompt continuity of care. Around midnight, Dr. Brigham received a call from Dr. Handley, a resident in ob/gyn, who wanted to discharge J.K. from the emergency room. She said the patient had a normal temperature and was not bleeding, although she was having contractions. Dr. Handley wanted to know if she could discharge J.K. to Dr. Brigham's care. Dr. Brigham noted in his testimony that J.K.'s situation must not have constituted a medical emergency in Dr. Handley's opinion, if she was seeking to discharge the patient. However, Dr. Brigham felt J.K. should be monitored for awhile, and he offered to come to the hospital to assist. Dr. Handley did not want him to do that, because he did not have privileges, and rather than discharging J.K. to her home, the hospital was to monitor her for a longer period.

It was Dr. Brigham's testimony that he called the hospital about an hour later and Dr. Handley told him that J.K. was having contractions every two minutes, and they would keep her. She said J.K. was febrile, and she asked for Dr. Brigham's suggestions. He said to draw blood for a culture and remove the laminaria, and he suggested an induction procedure. Dr. Handley agreed. At about 6:30 a.m., Dr. Brigham spoke to a labor and delivery nurse, who said that J.K. had spontaneously delivered the dead fetus around 5:30 that morning. The nurse described the procedures followed and the drugs used.

Dr. Brigham went that afternoon to visit J.K. in the hospital and asked her how she was feeling. She was angry and upset about comments hospital staff had made to her and she wanted to sign out, but Dr. Brigham advised her not to do that. He learned from a nurse that J.K. had tested positive for cocaine in her urine (Exhibit P-1B), and he spoke to her about that. J.K. admitted that she had been using cocaine heavily for about six months, but had not revealed it to him because she was afraid he would not help her.

Dr. Brigham testified that it is well documented in medical literature that cocaine can cause intrauterine fetal demise, and can also cause abrupt onset of labor almost immediately after usage. J.K. told him she had ingested cocaine after insertion of the laminaria. He noted that cocaine can also cause fever. However, he also noted that the patient had not met the criteria for febrile, as her temperature had been over 104 degrees for only 55 minutes, and was 103 degrees or higher for only two hours. In addition, not one of the three blood cultures taken to look for bacteria grew a culture, and her cervical culture was negative. In Dr. Brigham's opinion, there was no pathological confirmation of an infection from examination of the placenta, and no scientific validation of the hospital's

presumptive diagnosis of an infection.

Dr. Brigham testified sincerely and credibly that he believes his management of J.K. was within the generally accepted standard of care. What he did for her was insertion of laminaria, and every physician he knows who does late abortions sends the patient home after insertion of laminaria, to return the next day for completion of the procedure. Dr. Brigham believes that the plan he had for the remainder of J.K.'s care was also within the generally accepted standard of care. He characterized as ridiculous the assertion that insertion of laminaria in J.K. was the performance of an abortion, and he noted that if he had thought insertion of laminaria in J.K. violated the regulation, he would not have done it. According to Dr. Brigham, he has been told by some of Dr. Kotopolous' patients that he inserts laminaria when their membranes have ruptured, even when they have to travel. Dr. Brigham felt it was interesting that Dr. Kotopolous did not criticize him for insertion of laminaria when J.K.'s membranes had ruptured, but criticized him for almost everything else he did, while Dr. Hollander was mainly critical of that very action.

Dr. Michael Burnhill testified that D.I.C. is not seen in a recent fetal demise. However, if the demise had occurred a week or more before seeing the patient, he would do a bloodclotting profile. With patient J.K., the fetal demise was quite recent, so no clotting test was needed. Dr. Burnhill stated that he is unaware of any school of thought or publication which suggests that insertion of laminaria is contraindicated with a fetal demise and ruptured membranes. In his opinion, that circumstance presents two choices: either induce labor or increase dilatation until it is adequate to prepare for an evacuation procedure. Dr. Burnhill reviewed the J.K. records and noted that if a patient refused to go to the hospital, he would have to acquiesce. There are risks with inducing labor at the hospital and most women are traumatized psychologically by going into labor with a dead fetus. He concluded that there was no departure by Dr. Brigham from the generally accepted standard of care in his management of this patient. Dr. Burnhill was a candid and sincere witness.

Dr. A.K., who served as Dr. Brigham's monitor, testified that it is not a medical emergency if membranes rupture during insertion of laminaria. He has handled many patients with fetal demise, including ones with ruptured membranes, and it is his opinion that insertion of laminaria is the indicated procedure in such circumstances. He considers a recent demise to be within a week to ten days. Dr. A.K. sees no increase in the incidence of infection when laminaria are inserted in ruptured membranes, and he noted that laminaria can raise a patient's temperature, unrelated to any infection. When dilatation is adequate, the uterus can be evacuated. Dr. A.K. noted that he has patients who come to his Philadelphia office from as far away as Wilkes Barre, Pennsylvania, and Atlantic City, New Jersey, for laminaria insertion. They will then travel home and return later for the evacuation procedure. Dr. A.K. also noted that he does not have hospital admitting privileges in every area where his patients reside, and it is very appropriate in an emergency for a patient to go to an emergency room. That is what emergency rooms are for.

Dr. Jeffrey Moskowitz testified on behalf of respondent that he is familiar with patient J.K.'s records. He said that he has encountered ruptured membranes in second trimester abortion patients. About 40 percent of the patients at Eastern have been second trimester pregnancies, and Moskowitz estimated that about 8 to 10 percent of those have ruptures of membranes after insertion of laminaria. He does not consider that circumstance a medical emergency. Since the patient's objective is termination of the pregnancy, adequate dilatation of the cervix must be achieved. Thus, there may still be a need to insert more laminaria after rupture, and he does not believe this is a departure from generally accepted standards of medical care.

Dr. Moskowitz testified that a patient may be sent home after additional laminaria are inserted, to return when adequate dilatation is achieved. In his opinion, it makes no difference if there has been a fetal demise by the time of the membrane rupture. It is not a departure from standards if the patient must travel after insertion. In addition, Dr. Moskowitz testified that he has found no increased

incidence of infection in such cases. He also noted that many patients have vaginal bleeding when laminaria are inserted.

It was the testimony of Dr. Moskowitz that it was not a departure for respondent to not send J.K. to the hospital at the time of the ruptured membranes. He said the records revealed J.K. had bulging membranes when she appeared on the second day, and he testified that he would consider 2.4 cm. dilatation about one-half the dilatation necessary. He also noted that it is accepted practice in the United States for high volume abortion provider physicians to not have ob/gyn training. Not having local hospital admitting privileges is also not a departure, since many hospitals do not allow abortions on the premises. It is customary for many patients to travel great distances for abortions, particularly during the second trimester. However, he noted that he does have privileges at local hospitals.

Dr. Moskowitz testified that he saw no lapse in respondent's medical judgment or in his medical plan for J.K. He felt respondent acted in a manner consistent with accepted standards of care. Moskowitz noted that Brigham told him that he had back up arrangements with a physician who had hospital privileges, and Moskowitz said it was not necessary for the back up to have skill in doing abortions. Whoever it was would have to be willing to take care of a patient with complications from an abortion. While Moskowitz acknowledged that it may have been an alternative for respondent to have called his back up to examine J.K., there was no need to do that. The ruptured membrane is not considered a medical emergency, nor was it anything which required a second opinion.

DISCUSSION

Complainant contends that respondent had several reasonable medical alternatives available to him which would have been safer for the patient and some of which would have better ensured that the abortion would be completed via D&E. Respondent could have brought the patient to Queens for the D&E on the first day knowing she was carrying a dead fetus. He could have brought the patient to Queens once he saw that the membranes had ruptured, and could have further dilated the patient's cervix using manual dilators to complete the D&E at that time. Alternatively, respondent could have called his backup physician and asked that physician to take the patient on the second day and complete the abortion by the D&E method at a licensed abortion clinic or hospital.

Complainant contends that all of these were reasonable medical alternatives, and there was no necessity to stay with the original three-day plan. A patient's concerns regarding money cannot override the physician's exercise of appropriate judgment in knowing when to make appropriate referral arrangements which would be in the patient's best interest. Complainant argues that respondent's claim that there were no other safe or feasible alternative to what he chose to do in this case must be rejected.

Complainant contends that respondent Brigham deviated from generally accepted standards of care by undertaking the treatment of J.K. in his office. As noted above, it was the opinion of Dr. Kotopolous that Dr. Brigham should have diagnosed the condition of 24 weeks' pregnancy with intrauterine fetal demise, and then referred J.K. to a hospital where the procedure could be performed and attendant risks and complications addressed. Dr. Kotopolous opined that the possible complications of D.I.C. and severe infection could not be handled on an outpatient basis.

Significantly, Dr. Hollander was not in complete accord with Dr. Kotopolous. Dr. Hollander did not find fault with respondent's management of J.K. on the first day. Rather, his concern was with the insertion of additional laminaria on the second day, after the patient's membranes had ruptured and she was dilated at 2.4 centimeters. He opined that Dr. Brigham should have promptly referred J.K. to the nearest hospital or other facility or to another physician for completion of the procedure, or he could have taken her to New York on the second day to complete the procedure himself. As noted above, both Dr. Hollander and Dr. Kotopolous felt that

it was a gross deviation from the generally accepted standards of care for Dr. Brigham not to have chosen one of the alternatives available to him and to instead stay with his original plan of treatment. Complainant argues that respondent's care of J.K. placed her at risk of harm and was a gross departure or extremely high deviation from accepted standards of care.

Respondent argues that he exercised reasonable, sound and prudent medical judgment in his management of this patient. He emphasizes that through his care, J.K. did not suffer either any injury, nor any scientifically established increased risk of injury. It was the unrefuted testimony of Dr. Moskowitz that in a study of more than three thousand patients like J.K., insertion of laminaria in a patient with ruptured membranes did not cause any increased risk of complication. Similarly, a recent fetal demise did not increase risk of complication. It is respondent's position that J.K.'s situation was no different than that of a patient who had an induced fetal demise with digoxin in preparation for a late abortion.

Respondent acknowledges that he did not include in his medical note every comment and remark exchanged with the patient. He deliberately did not include details of J.K.'s marital problems or suicidal thoughts, yet J.K. confirmed these matters in her unrefuted and credible testimony. Respondent further contends that it must be remembered that J.K. was a highly non-compliant patient, even by her own admission. She ingested cocaine, which likely induced labor and elevated her temperature. She did not take the antibiotics given to her; she rode a motorcycle against Dr. Brigham's advice, and she flatly refused his advice to go to the hospital. The patient's actions and decisions curtailed the respondent's options. Under the circumstances the patient presented, Dr. Brigham reasonably exercised his medical judgment in the patient's best interest, and within generally accepted standards of care. Because of her refusal, the respondent did not have available the option to send J.K. to the hospital, and to perform the procedure with inadequate or barely adequate dilation would subject her to greater risk. Respondent also argues that manual dilators would have subjected the patient to risks, while the insertion of laminaria was safer.

Respondent also emphasizes that complainant has made no effort to reconcile the completely contradictory opinions of Dr. Kotopolous and Dr. Hollander as to why respondent was negligent. While Dr. Hollander found no fault with Dr. Brigham's care of J.K. on the first day, Dr. Kotopolous was critical of almost everything he did. While Dr. Hollander criticized Dr. Brigham for inserting laminaria on the second day after rupture of the membranes, Dr. Kotopolous mentioned no criticism of that practice. The complainant did not attempt to refute the respondent's evidence that Dr. Kotopolous himself inserts laminaria in ruptured membranes. Thus, what Dr. Kotopolous claims to be negligence, Dr. Hollander says is not, and what Dr. Holander claims is negligence raises no criticism from Dr. Kotopolous.

Aside from the inherent contradiction in the opinions of the complainant's expert witness, respondent asserts that management of a patient with a late second term intrauterine fetal demise is acceptable as an outpatient D&E procedure. As testified to by Dr. Burnhill, Dr. Moskowitz, Dr. K., and Dr. Brigham, the National Abortion Federation, the Planned Parenthood Federation of America, and the Precis V all support this approach. Dr. Hollander did not disagree. Patient J.K. had a very recent fetal demise, so the risk of D.I.C. was minimal, and there was actually no increased risk of infection, according to Dr. Burnhill and Dr. Moskowitz. Dr. Moskowitz would have handled patient J.K. at his state-licensed facility in the same manner Dr. Brigham did, and his facility's protocols are reviewed and approved by the State of New York.

I agree with the respondent's contentions. The complainant has failed to meet her burden of persuasion. I FIND that respondent's treatment plan for J.K. was consistent with generally accepted standards of care, and the medical judgment exercised by respondent was sound and reasonable. Using his skills, knowledge, and observations, respondent established that J.K. had a recent fetal demise and clotting was present, eliminating undue concern for D.I.C. and infection. Respondent's options were subsequently limited by the patient's circumstances and non-compliant attitude, but he continued to practice good and caring medicine. I

FIND that insertion of laminaria in ruptured membranes was not a departure from generally accepted standards of care, and that respondent did not subject J.K. to enhanced risk of hemorrhage and infection. The reliable evidence in the record established that it is customary for patients to return to their homes following insertion of laminaria, while adequate dilation is achieved, and it is not the standard of care that back-up arrangements be available near each patient's home. After ingesting cocaine, J.K. had a fever for at most three hours. Respondent properly recommended at the appropriate times that J.K. go to the hospital, and eventually she stopped refusing and went. Respondent then appropriately followed up on the patient's care at the hospital.

Based on the foregoing, I further FIND that respondent Brigham's conduct concerning patient J.K. did not constitute gross or repeated acts of negligence, malpractice or incompetence, nor professional misconduct, and that he did not exhibit poor judgment calling into question his ability to safely practice medicine in this State. Thus, I CONCLUDE that respondent's conduct did not constitute grounds pursuant to N.J.S.A. 45:9-16 and N.J.S.A. 45:1-21(c), (d), (e) and (h) forthe revocation or suspension of his license to practice medicine and surgery in this State.

The issue of whether respondent violated the termination of pregnancy regulation, N.J.A.C. 13:35-4.2, by inserting laminaria in a patient who was beyond the 14th week LMP will be addressed below.

The Case of A.W. (Amended Complaint, Count III)

Complainant alleges that respondent Brigham's conduct concerning patient A.W., constitutes gross and repeated acts of negligence, malpractice, or incompetence. Complainant asserts that this conduct constitutes grounds pursuant to N.J.S.A. 45:9-16 and N.J.S.A. 45:1-21(c) and (d) for the revocation or suspension of his license to practice medicine in this State. Complainant further alleges that respondent's conduct, when taken in combination with conduct alleged in other counts of the complaint, constitutes repeated acts of negligence, malpractice or incompetence, thereby constituting grounds pursuant to N.J.S.A. 45:1-21(d) for the revocation or suspension of his license to practice medicine in this State. The allegations concerning respondent's care of A.W. are that his conduct jeopardized her health and life by failing to quickly recognize that he had perforated her uterus, and by continuing to operate on the patient outside the uterus, and by therefore causing extensive damage. The injuries alleged are an eight to ten centimeter laceration of the uterus, bilateral pelvic peritoneal lacerations, disruption of the sigmoid mesentery, transmural laceration of the sigmoid colon, fecal contamination of the peritoneal cavity, and extensive damage to the ureters.

The findings of fact which follow are derived from the credible evidence in the record. A.W. sought an abortion because she learned late in her second trimester that she was carrying a fetus with multiple congenital anomalies which rendered it nonviable. She was at 24 weeks when Dr. Brigham examined her. He recalled that she had been referred by the Hershey Medical Center and that numerous Pennsylvania doctors had declined to do the procedure. After ascertaining that adequate dilatation was achieved, Dr. Brigham commenced the abortion at 11:30 a.m. on May 9, 1992, at Flushing Gynecology Center in Forest Hills, Queens, under general anesthesia and using real time ultrasound. According to Dr. Brigham, the ultrasound gave exquisite lateral views, but it's only two dimensional, meaning that the procedure remains blind in the anterior/posterior plane.

Dr. Brigham testified that with an abnormal fetus such as this, it was not clear how it would feel when grasped with forceps. Similarly, the placenta was abnormal and that would affect the degree of invasion of the uterine wall. He removed a limb of the fetus and the placenta. He now believes that an eight to ten centimeter tear in the uterine wall occurred when he grasped and removed the placenta.

Dr. Brigham next attempted to grasp the fetal skull with large McMahon forceps (Exhibit R-10). The McMahon forceps are large enough to reach from one end of the

pelvis to the other when open. In doing grasping, Dr. Brigham felt soft tissue. The image on the ultrasound indicated to him that his forceps were around the fetal skull. However, he now knows that his forceps were actually behind the fetal skull and outside the uterus, rather than around the fetal skull.

Dr. Brigham made small exploratory movements of the forceps from side to side and up and down with a rotating motion of his wrist, in an effort to find the fetal skull. When he closed the forceps to grasp the tissue, it felt soft and mushy, but he thought this might be due to the fetal abnormality of hydrocephaly. However, when he pulled down the tissue which he thought was the fetal skull, he saw that he had grasped omentum and he then knew that his forceps had been outside the uterus.

Dr. Brigham testified that it was hard for him to say how wide he had opened the forceps. He thought about 10 inches, but he could not say for sure. He suggested that 10 inches was the maximum; it may have been less, but he did not think it was more. Dr. Brigham acknowledged that he may have said in his testimony in the State of New York that he opened the forceps no more than 10 to 15 centimeters, which would be four to six inches. He did not believe that he moved the forceps in and out of the uterine perforation more than once.

The structures Dr. Brigham had contacted with the forceps were actually in A.W.'s pelvic area, rather than fetal tissue in her uterus. Upon seeing the omentum, he immediately stopped the procedure and called Dr. Dengelegi to arrange to have A.W. promptly admitted to Elmhurst Hospital. She was given intravenous pitocin in the recovery room to decrease bleeding, and Dr. Brigham then accompanied her to the hospital in the ambulance.

At surgery, the fetus was found to be extruding into the pelvic cavity from a posterior uterine perforation of eight to ten centimeters in length. The fetus was removed and the perforation was repaired. It is more likely than not that the perforation was originally smaller and was extended by uterine contractions pushing the fetus through the perforation. The surgeons repaired the other injuries. The left ureter had been transected, while the right ureter had a small nick which was repaired with a single suture. There were peritoneal lacerations. The surgery chief resident reported a perforation of A.W.'s sigmoid colon through its mesentery, and a section of the mucosa was denuded and devascularized (Exhibit P-5). A section of the colon was removed and sent to pathology, and a temporary colostomy was performed. However, the pathologists did not note any perforation of the sigmoid colon. A.W. did not require a hysterectomy, and she was subsequently discharged to home in good condition.

Dr. Kotopolous offered his opinion on how a physician recognizes that a perforation in the uterus has happened in a 23 week procedure. He stated, "This is where the experience of the surgeon comes in to realize that a perforation happened, to realize that he started in a certain direction into the uterus and then all of a sudden his instruments are in a different direction, different from the initial direction, and he's working in an area outside the uterus." It was Dr. Kotopolous' opinion that Dr. Brigham did not immediately recognize that he had perforated the uterus, and the location of the injuries to the patient suggested that Dr. Brigham put his instrument through the perforation more than once or twice. It was his view that Dr. Brigham had deviated from the generally accepted standards of care in failing to recognize the uterine perforation. However, he agreed that failing to immediately recognize a perforation is not necessarily negligent, even if it results in injury to the abdominal aorta which causes death.

Dr. Hollander also reviewed the records concerning A.W., and he acknowledged that perforations do happen during abortions. He said that just failing to immediately recognize the perforation, without more, would not be negligent. However, in this case, there was more. There was movement of the forceps in different directions and the striking of organs in different planes with the forceps. In Dr. Hollander's opinion, a surgeon can tell there has been a perforation in several ways: by feeling the instrument go through the uterus; by symptoms like loss of blood or by seeing tissue damage, or by realizing the instrument is going further than the understood size of the uterus. When any of these indicia occur, the physician

should stop the procedure. It was Dr. Hollander's opinion that respondent did not immediately recognize that he had perforated A.W.'s uterus because his instrument had injured both her left and right sides, outside the uterine perforation. He did not see anatomically how all the injuries could have been caused by just one opening and closing of the instrument, and he considered this to be a deviation from the generally accepted standard of care.

Dr. Policar testified that he reviewed the records concerning A.W., and he concluded that Dr. Brigham did not depart from the standard of care. The placenta was on the posterior wall, which meant that it was likely that the uterine wall was even thinner than it might have been if the placenta were attached elsewhere. Dr. Policar estimated the rate of uterine perforations in late abortions to be two to five per one thousand procedures. At the San Francisco Hospital, almost all of the perforations in late abortions are posterior, and it's even more likely when there is a posterior placenta.

According to Dr. Policar, the large forceps are inserted closed, and are not removed until a fetal tissue structure is firmly grasped and removed. It is a blind procedure and the physician works by feel. Dr. Policar stated that there is no way of knowing specifically what tissues are being grasped. The first indication Dr. Brigham had of the perforation of the uterus was when he saw omentum being extracted. Dr. Policar testified that the insertion of the forceps alone could have perforated the uterine wall, and a single opening and turning of the forceps could have caused the injuries to the patient, because of the large span of the forceps (Exhibit R-10).

Dr. Policar further explained that the injuries to A.W. could have occurred with one pass of the forceps through the uterine wall, if the forceps were then moved around within the pelvis. The injured organs were to the left, to the right, and to the back, so there must have been some degree of movement of the forceps after they were passed through the uterine wall. Although Dr. Policar testified that he has never done an abortion procedure where there was a uterine perforation and injury to organs on the left, right, and back, he also said these complications to A.W. could have happened in the best of hands. In fact, it would not be a departure from generally accepted standards of care in a late second trimester abortion to have a perforated uterus and injury to the aortic artery which causes the patient to bleed to death. The physician must open and close the large forceps to grasp tissue, so Dr. Brigham's movements of the forceps would be integral to properly performing the procedure, and he did not depart from the generally accepted standards of care. In Dr. Policar's opinion, there was no gross negligence, nor repeated acts of negligence, nor any negligence in Dr. Brigham's handling of this patient.

Dr. Moskowitz testified that he reviewed the patient record concerning A.W., and he found no problems with the medical judgment exercised by respondent. First, perforations of the uterus are a known complication, and he felt there was no departure from generally accepted standards of medical care with the occurrence of the perforation during this abortion. He explained that the uterus has a fixed amount of muscle and the later the pregnancy, the thinner and softer the uterine wall becomes. The wall has less resistance to the pressure of an instrument, which may then pass through the uterine wall.

Dr. Moskowitz testified that it is not a departure from the accepted standard of medical care for a physician to not immediately recognize that there has been a perforation. The physician can not see beyond the end of the cervix and can not see inside the uterus. He must operate by feel. The instruments are quite long and have a fulcrum effect; a small opening of the part of the instrument outside of the uterus creates quite a large opening at the other end. He opined that an 8 to 10 cm. rent in the uterine wall does not indicated a departure, but he agreed that it was in the category of a large perforation. In regard to A.W.'s injuries outside the uterus, Dr. Moskowitz did not believe their location indicated the physician lacked skill or ability, nor were they a departure from good and accepted standards of care, because it is a blind procedure and the uterus is very, very soft. He acknowledged that if the physician is operating outside the uterus it is inappropriate, since that is not part of the abortion procedure, but he did not

feel it was a departure.

Dr. Moskowitz agreed that if there has been a perforation and the physician believes he is still operating inside the uterus, but is actually not, movement of the instrument can cause several injuries. He noted that in his career at Eastern, and in his review of charts over the last ten years, he has seen circumstances similar to A.W.'s injuries. He said there were injuries to the sigmoid colon and there were injuries to each ureter. However, he acknowledged that he had never before seen injury to both ureters and the sigmoid colon in the same patient. He characterized these injuries as a major complication. Nevertheless, Moskowitz testified that Dr. Brigham realized there was a complication upon seeing omentum, and Moskowitz did not believe this was a departure. Calling for hospital admission and riding there with the patient was also appropriate.

Dr. Michael Burnhill noted that a physician does not need to be an ob/gyn or need to have done an ob/gyn residency to competently perform abortions. Even a Board certified ob/gyn physician must be trained by an abortion practitioner to perform the procedure properly. According to Dr. Burnhill, there are many prominent abortion providers who are not ob/gyns.

In regard to patient A.W., it was Dr. Burnhill's testimony that a perforated uterus does not necessarily indicate malpractice or incompetence because the physician does not know how thick the uterine wall will be, and there may be surgical or congenital reasons for a weakening of the uterine wall. In addition, the size of the uterine cavity can vary, the patient can move, and the uterus is a muscular organ that relaxes and contracts from moment to moment. The physician can only approximate by feel and experience where his instrument is in the uterus, and he characterized the process as an art form as well as a skill.

Dr. Burnhill testified that an 8 to 10 cm. perforation of the uterus would not indicate a departure from the generally accepted standard of care; in late second trimester abortions the instruments are large, so lacerations tend to be larger. The risk of perforation is part of a patient's informed consent. Similarly, because the grasping forces tend to be large, injuries following perforation tend to be extensive. According to Dr. Burnhill, the problem is recognizing when the uterus has been perforated; the wall is so thin that the physician may have no sense of a perforation and will be probing with the instrument for fetal parts. There is a lot of room inside the uterus, so having a lot of room to move the instrument would not be a clue that the instrument is extrauterine. Often, a physician will not be aware that he is working outside of the uterus until he brings down some tissue that discloses it.

Dr. Burnhill testified in essence that a physician who performs many late second trimester abortions will eventually have a perforation and injuries to the patient. He acknowledged that there is not a strong likelihood of a perforation and that a perforation might be the result of negligence. Dr. Burnhill stated that the number one cause of negligent perforations in late second trimester abortions is failure to obtain correct cervical dilatation; fetal parts may cut the uterine artery as they are pulled through the cervix. The second most likely cause of negligent complications is lack of appropriate training. Other causes of negligent injury would be failure to ascertain the gestational age and a physician who in an impaired state. In Dr. Burnhill's opinion, there was no departure from the generally accepted standard of care in Dr. Brigham's treatment of A.W., although there was certainly a terrible result.

DISCUSSION

Complainant argues for rejection of respondent's theory that all of the injuries occurred during one single ten-inch opening and closing of the forceps through the uterine perforation. First, respondent admitted during cross-examination that there were multiple smaller movements of his forceps as well as the single large opening and closing. Second, the injuries were not all on the same plane. The uterine perforation was an uncommonly large 10 cm (4 inches) vertical perforation. The

injured organs were above, below, to the right and to the left of the location of that perforation. Complainant asserts that there had to have been multiple movements of the forceps in different directions within the abdominal cavity and outside of the uterus to cause all of this damage. Complainant argues that while it is likely that there was more than one pass of the forceps through the uterine perforation, even if there was only one large opening and closing motion, there had to have been multiple other movements of the forceps in the pelvis.

Complainant acknowledges that a uterine perforation can occur during an abortion without there necessarily being negligence on the part of the physician. However, complainant contends it was respondent's negligent failure to promptly recognize that the perforation occurred which caused the extensive damage to the patient. Even using real-time ultrasound, respondent did not realize he was operating outside the uterus when he was making his exploratory movements and small closing maneuvers with his forceps. Difficulty may be caused by the fact that the uterus can contract and move. A physician performing late second trimester abortions would presumably be aware of this phenomena and could use his hand on the patient's abdomen to aid him in performing the abortion safely.

Respondent contends that he handled A.W.'s difficult late second trimester abortion appropriately, skillfully, and competently, with no departures from accepted standards of care. Uterine perforations are known and accepted complications of abortion. With A.W.'s thin uterine wall and fetal anomalies, Dr. Brigham could not immediately determine when the uterus was perforated by the large forceps.

Respondent argues that the evidence establishes that simply opening the large forceps outside the uterus could reach the left and right ureter. Once closing could nick one ureter and transect the other, and cause injury to the colon and peritoneum. It is respondent's argument that there is absolutely no indication that he improperly continued to operate outside the uterus, or caused extensive injury inconsistent with one opening and closing of the forceps.

I agree with the respondent's contentions. The complainant has failed to meet her burden of persuasion. The credible evidence and the substantial weight of expert opinion support respondent's position. If a physician has brought the requisite degree of care and skill to his patient, he is not liable simply because of failure to cure or for bad results that may follow. Schueler v. Strelinger, 43 N.J. 330, 344 (1964). The experts who offered opinions on respondent's behalf testified persuasively that it is quite possible for the injuries to have been cause by one pass through the uterine perforation, with tilting of the forceps in different angles looking for fetal tissues, just as respondent described. This is not a departure from the generally accepted standards of care. I FIND that respondent quickly recognized that he had perforated A.W.'s uterus and had injured her and that he did not deviate from generally accepted standards of care when he unintentionally operated on her outside the uterus.

Based on the foregoing, I further FIND that respondent Brigham's conduct concerning patient A.W. did not constitute gross or repeated acts of negligence, malpractice, or incompetence. Thus, I CONCLUDE that respondent's conduct did not constitute grounds pursuant to N.J.S.A. 45:9-16 and N.J.S.A. 45:1-21(c) and (d) for the revocation or suspension of his license to practice medicine and surgery in this State.

The Case of Y.B. (Amended Complaint, Count IX)

Complainant alleges that respondent Brigham's conduct concerning patient Y.B. constitutes gross or repeated acts of negligence, malpractice, or incompetence, as well as professional misconduct. Complainant asserts that this conduct constitutes grounds pursuant to N.J.S.A. 45:1-21(c), (d), and (e) for the suspension or revocation of his license to practice medicine and surgery in this State. The allegations concerning respondent's care of Y.B. are that he administered a normal dose of conscious sedation to her, and then administered another half dose without

waiting to see if the first dose had the necessary effect. Complainant alleges that respondent then place a handful of gauze into the patient's mouth, creating a risk of airway obstruction. Complainant further alleges that the respondent's nursing staff had difficulty arousing the patient following the procedure, had to hold her up to walk to the recovery room, and had difficulty maintaining her in a state of arousal without stimulation from ammonia salts, verbal commands, and physical contact.

The findings of fact which follow are derived from the credible evidence in the record. Y.B. was fourteen years old when she came to respondent's office on October 26, 1993, with her mother. She was six weeks pregnant by dates and by pelvic exam (P-33), and she was suffering from vomiting because of her pregnancy. She previously had an abortion at Dr. Kotopolous' facility in Englewood when she was 13. Y.B. was 5 feet tall and weighed just 102 pounds. Once in the examination room, she was crying and visibly scared to be there, even though she had experienced the prior abortion. She was crying during the pelvic exam and also was crying very hard during the process of attaining I.V. access.

Lynette (Campbell) Zielke, R.N., was the registered nurse who was working with respondent and attempted to insert the IV needle into Y.B.'s arm. Ms. Zielke has been a registered nurse for over 11 years, with experience working in several hospitals on respiratory and surgical units. She is presently a community health nurse who assesses and monitors patients who have been discharged from the hospital. Ms. Zielke is certified in advanced cardiac life support, has CPR certification, and is certified in I.V. conscious sedation from a nursing perspective. Her experience includes seven years of work at Cooper Hospital recovering patients from intravenous conscious sedation, specifically including Versed and Fentanyl. She began working at respondent's office in late June 1993, assisting with procedures and examination of patients.

Ms. Zielke testified that she attempted to obtain I.V. access in Y.B.'s right arm but had difficulty because the patient was upset and very tense. Recognizing this problem with the patient, she asked respondent to obtain access, and he did so. Ms. Zielke testified that the patient was still upset. According to Ms. Zielke, Dr. Brigham administered the first dose of medication, and then he turned around and grabbed some gauze. She testified that without saying anything, Brigham put it in the patient's mouth. Ms. Zielke testified that she then whispered to him, "Are you sure you want to do that?" He said that he did; and that he wanted to give her a little extra sedation, too, because she needed it.

It was Ms. Zielke's testimony that Dr. Brigham then looked at Y.B. and told her to bite down on the gauze. Then he turned around and took another syringe. Ms. Zielke said that she protested that the patient was only 14 and looked like she weighed 85 pounds. Respondent said she'd be okay, and Ms. Zielke further protested that they would not be able to wake her up later. Ms. Zielke said that this protest elicited no response from the respondent. She testified that the respondent later told her that he was concerned that the patients in the waiting room would hear Y.B. crying and would become upset.

According to Ms. Zielke, while respondent was administering the second dose, Y.B. still had the gauze hanging out of the front of her mouth. Ms. Zielke asked the patient if she was okay, and the patient shook her head that she was. In Ms. Zielke's estimation, there was less than a five second delay between the first dose and the second dose, so that the initial dose was not observed for effect before the second dose was put in.

The anesthesia used on Y.B. was known as "conscious sedation," a combination of Fentanyl or Sublimaze and Versed. The syringes were prefilled with these two drugs, although the respondent could change the dose at time of administration. A single syringe contained the standard dose. Respondent gave Y.B. a dose and a half, using a full syringe and then a half of another. The record (P-33) reflects that the total quantity of sedation administered was 3 mg. Midazolam (Versed) and 112.5 mcg. of Fentanyl.

After administering the second dose, respondent sat down at the foot of the table and started to open his equipment to begin the procedure. At that time, Ms. Zielke took the gauze out of Y.B.'s mouth. She testified that she did this because she did not think it was a safe situation. Ms. Zielke thought it was unsafe because of obstruction of the airway and obstruction of the patient's ability to communicate. In the years she had worked as a nurse, she had not seen other physicians use gauze in this way. Ms. Zielke testified that it would surprise her if she heard that other physicians even of good credentials utilized gauze in the way respondent did with Y.B.

Y.B.'s oxygen saturations were monitored using a pulse oximeter, and the nurse had to watch for saturation dipping below 90. While respondent was in the room, Y.B.'s oxygen saturation level never stayed below 90. The abortion took about four minutes. According to Ms. Zielke, Y.B. was very lethargic as an effect of the sedation she had been given. Witness B.G. agreed that by the end of the procedure, Y.B. was extremely drowsy. Ms. Zielke found that as they tried to arouse Y.B. after the abortion, she was groaning and not forming full sentences. She was not sitting up on her own. Her breathing was slow and shallow and she needed stimulation to take a deep breath, which also showed the effect of the sedation. They sat her up, but she could not sit on her own and they had to hold her up. According to Ms. Zielke, Y.B. needed smelling salts, but when they were taken away, the patient returned to shallow respirations.

Ms. Zielke asked someone to bring Dr. Brigham back in. When he arrived, she told him that the patient's pulse oximetry reading was dropping to 85 and she could not keep it up. She said there were several pulse oximetry readings which were down at 85. Dr. Brigham then removed the pulse oximeter and told the nurse to stand the patient up, but Ms. Zielke told him that Y.B. could not stand. They then took Y.B. off the table. According to Ms. Zielke, she was holding Y.B. up because she felt the patient would otherwise fall. She said that the respondent wanted her to let go of the patient.

Ms. Zielke set Y.B. up in the recovery room, where she was monitored for heart rate, pulse and blood pressure until her vital signs were all stable and she did not need stimulation to take deep breaths. After the patient was stabilized, Ms. Zielke spoke at length with respondent about the quality of the care that had been provided for this patient. She let him know that she could not condone how he practiced. According to Ms. Zielke, he asked her not to leave and wanted to know if she would stay if he promised he would never put gauze in anybody's mouth when she was in the room. Zielke testified that she responded she could not work for anybody who thought that was okay to begin with. Respondent indicated he was more experienced and that it was a common practice. She stated that he offered to buy any safety equipment she suggested and he indicated he was concerned about other patients in the waiting area hearing the crying girl. Ms. Zielke said that she did not agree with his choice between hearing a patient cry or gag. Ms. Zielke quit respondent's employ, even though she had two children to support and quitting meant she would lose 20 percent of her income.

Dr. Brigham agreed that Y.B. was frightened and anxious in general. She previously had a painful experience with an IV insertion and was apprehensive. A second assistant, B.G., was brought in to hold the patient's hand and talk to her. According to Dr. Brigham, Y.B. tolerated the pelvic examination pretty well and he was able to apply local anesthesia around the cervix. Meanwhile, Ms. Zielke was trying to insert the IV needle in the patient's arm vein. This caused Y.B. to be even more afraid and to move even more, which made it more difficult to insert the needle. At that point, Ms. Zielke asked for Dr. Brigham's help to insert the needle.

Dr. Brigham testified that he then got up from where he was and touched the patient's arm and spoke to her, trying to calm her. He testified that he told Y.B. he was going to take some four inch by four inch gauze and she should bite on it, and then they would be able to get the IV in for some sedation. B.G. stroked the patient's hair and reassured her that Dr. Brigham was really good at inserting needles. According to Dr. Brigham, having patients bite on gauze to distract them

from the needle insertion is a technique he had observed and had used with many patients, especially the elderly. He had found it to be very effective and never had a problem with it. It was Dr. Brigham's opinion that the process of the patient clenching her teeth on the gauze and holding the mouth shut actually prevents obstruction of the airway.

Dr. Brigham stated that he took a sterile piece of gauze and folded it up, then inserted it between the patient's upper and lower teeth on the left side of her jaw, with most of the gauze protruding out of her mouth. He believes he told her to grit her teeth, and he said she seemed to be gearing herself up to do as he said and to try to be brave. Ms. Zielke asked Y.B. if she was okay with the gauze in her mouth and she nodded that she was. Dr. Brigham then used a tourniquet on Y.B.'s arm and found the vein. He told her she would feel a little pinch. The needle went right in and he released the fluid. At that point, Ms. Zielke reached over and removed the gauze and Dr. Brigham told her okay, although he had the impression Ms. Zielke had surprised the patient.

According to Dr. Brigham, Fentanyl is a narcotic analgesic used to dull the patient's sense of pain, and it has some sedative effect. Versed is a tranquilizer intended for calming anxious patients. It also has the effect of blocking a patient's memory. Many patients who have had conscious sedation think they have been asleep during the procedure when they were actually able to have a conversation with the physician. Dr. Brigham estimated that he has used these two medications in combination several thousand times without difficulty.

It was Dr. Brigham's testimony that the patient's fright and crying caused him to decide to increase the sedation. He stated that he did not want Y.B. to be scared, and he wanted to calm her for a painless and safe procedure. He felt that if she were moving around during the abortion, the risk of uterine puncture would be increased. So, it was his medical judgment to increase the sedation. Dr. Brigham testified that he started with a dose of 2 mg. Versed and 75 mcg Fentanyl, and he said that this takes 20 to 40 seconds to reach the brain.

Y.B.'s crying stopped and her pulse rate fell appropriately, but Dr. Brigham felt she was still frightened and anxious. It was his testimony that he felt after observing her for a minute or two that she would benefit from an additional 1 mg. of Versed and 37 and one-half mcg. of Fentanyl. He explained that the time interval between doses was actually about one minute, after completion of the first dose, which he took about 30 seconds to slowly administer. He wrote what he observed in Y.B.'s chart (Exhibit P-33), and he noted that the time shown there for observation is not 3.0 seconds, but looks that way because there was probably a speck on the paper that looks like a decimal point on the copy.

In Dr. Brigham's opinion, he waited and observed sufficiently long after giving the first dose before administering the second dose. He feels that the total amounts administered would have been appropriate even if they were administered all at once, as it was not a large dose and still constituted conscious sedation by far. Dr. Brigham did not understand why Ms. Zielke was concerned about Y.B.'s sedation. After he performed another procedure in another room, which took three or four minutes, Dr. Brigham returned and observed that Y.B. was sitting up and talking, but was still sedated.

In Dr. Brigham's opinion, Y.B. was fine, with a slow, steady pulse and no respiratory distress, and she was simply still sedated. He took the patient's arm and she then walked under her own power into the recovery room. Y.B. was in no danger, and she thanked the doctor on her way out. Dr. Brigham testified that Y.B. subsequently returned for another abortion and thanked him again for the prior procedure. He gave her the same dose of medication and she again did fine. It was Dr. Brigham's sincere opinion that Y.B. was well served by him and there was no gross negligence, nor was there any departure from generally accepted standards of medical care. Patient Y.B. testified on his behalf, and explained how the gauze was carefully placed between her teeth, with much of it hanging out of her mouth. She felt Dr. Brigham was kind and respectful toward her.

The material factual dispute apparent from review of Ms. Zielke's and Dr. Brigham's testimony is whether the folded gauze remained between Y.B.'s clenched teeth after Dr. Brigham began administering the conscious sedation. It is clear that the purpose of the gauze was to calm the patient by distracting her from the process of inserting the IV needle. When that purpose was accomplished, the gauze was no longer needed. Thus, it is more likely than not that the gauze did not remain between Y.B.'s clenched teeth after Dr. Brigham began to administer the conscious sedation.

It was the opinion of Dr. Kotopolous that the insertion of gauze in a patient's mouth who is receiving conscious sedation is not within the generally accepted standard of care. He feels the dosage of sedation itself could suppress respiration, so obstructing the airway can compound the problem. Dr. Kotopolous testified that he is indirectly familiar with the effects of conscious sedation. He has an anesthesiologist administer it to his patients. It was also Dr. Kotopolous' opinion that the usual dose of conscious sedation is two milligrams, given one milligram at a time, every two to three minutes. He testified that Dr. Brigham did not follow this standard.

By affidavit, Dr. Carl Weiner, a New Jersey and New York licensed physician who provides anesthesia services at All Women's Medical Pavilion in Queens, New York, stated that it is not inappropriate to have a patient bite down on rolled up gauze to distract her while an IV needle is being inserted into her arm for administration of conscious sedation (Exhibit R-21). This affidavit also stated that there is a dose requirement variation from patient to patient, and this is particularly true for a patient who is anxious, frightened, and upset. He has personally administered doses of midazolam greater than 3 milligrams with no ill effects toward his patients, and he does not believe such administration would be any departure from accepted standards of care for the administration of conscious sedation.

Dr. Philip Stubblefield, who wrote the pregnancy termination chapter of the Precis V of the American College of Obstetricians and Gynecologists, stated in an affidavit (Exhibit R-57) that there are many regimens of medications that are perfectly acceptable and commonly utilized for conscious sedation during abortion procedures. According to Dr. Stubblefield,

> A regimen of two milligrams of midazolam and seventy-five micrograms of fentanyl, followed by an additional dose of one milligram of midazolam and 37.5 micrograms of fentanyl, which results in a total dose administered of 3 milligrams of midazolam and 112.5 micrograms of fentanyl, could be a perfectly acceptable regimen for conscious sedation for an anxious and frightened patient undergoing an abortion procedure. These dosages would in no way indicate "overdose" of the patient. This regimen would be consistent with acceptable standards of care, and prudent judgment.

Dr. Burnhill also had studied Y.B.'s records. It was his opinion that the dosage for conscious sedation must be individualized to the patient, and that the dosage given Y.B. was no departure from generally accepted standards of care. According to Dr. Burnhill, the patient's weight was not strictly relevant; the dose required had more to do with the patient's level of agitation. Dr. Burnhill acknowledged that a physician must wait between doses, but he stated that the drug is fast acting and it would not take long to see if a second dose were necessary. He noted that the patient's oxygen saturation was fine and that the variations were not significant. In his opinion, the use of the gauze was a distractive technique because it utilized teeth clenching, and he did not consider it a departure from generally accepted standards of care.

DISCUSSION

Complainant contends that respondent Brigham should have instructed patient Y.B. to return a few days later for her abortion, when she might have been calmer and would not have required so much sedation. There was no medical or legal necessity to perform the abortion that day. Complainant also contends that respondent did not

wait a sufficient amount of time before administering the additional dose of conscious sedation. When administering conscious sedation, it is important to maintain an open airway and monitor the patient's respiratory status. Complainant argues that by stuffing gauze in the patient's mouth, the physician has obstructed the airway and compounded the problem that may have been caused by oversedation.

Respondent replies that there is no reason to believe Y.B. would have been any less upset on another day, and she was also in danger of dehydration from her vomiting due to her pregnancy. It was a reasonable exercise of medical judgment to proceed with the abortion that day, even if it involved slightly more anesthesia. Respondent contends that he carefully placed folded gauze between Y.B.'s teeth and had her bite down, as a distractive and calming technique so he could insert the IV needle. In no way was the patient's airway obstructed. He objects to complainant's characterization of "stuffing gauze in the patient's mouth," as no one has said that is what happened.

Respondent further contends that he administered the proper dosage of conscious sedation to patient Y.B., in two stages, and that he waited a sufficient time between them to assess the effects of the first stage. This contention is supported by experts in the field. The sedation worked as it was supposed to, and the abortion was successfully completed. The patient's oxygen saturation fell only momentarily below 90 percent, which was not indicative of any complication. The patient was soon able to walk to the recovery room and was pleased with her treatment, with no ill effects.

I agree with the respondent's contentions. The complainant has failed to meet her burden of persuasion. I FIND that Dr. Brigham properly exercised his clinical judgment to give his anxious and frightened patient an appropriate dosage and effective combination of medications, and he did not depart from generally accepted standards of care. That his medical judgment was sound is supported by persuasive expert practitioners. I FIND that Dr. Brigham did not stuff gauze in Y.B.'s mouth while she was undergoing conscious sedation; rather, Dr. Brigham had the patient bite down on a piece of folded gauze to distract and calm her while he inserted the IV needle. I FIND that the gauze did not obstruct the patient's airway and it was removed before the conscious sedation was administered. I further FIND that patient Y.B. appropriately responded to the conscious sedation and experienced no respiratory distress. She was able to walk to the recovery room following the procedure and had a normal recovery from the anesthesia.

Based on the foregoing, I further FIND that respondent Brigham's conduct concerning patient Y.B. did not constitute gross or repeated acts of negligence, malpractice, or incompetence, nor professional misconduct. Thus, I CONCLUDE that respondent's conduct did not constitute grounds pursuant to N.J.S.A. 45:1-21(c), (d), and (e) for the suspension or revocation of his license to practice medicine and surgery in this State.

The Case of M.B. (Second Complaint, Count I)

Complainant alleges that respondent Brigham's conduct concerning patient M.B. constitutes gross or repeated acts of negligence, malpractice or incompetence as well as professional misconduct; endangerment of M.B.'s life; and medical judgment contrary to the safety and well-being of the public of this State. Complainant further contends that respondent's alleged acts and failures concerning M.B. constitute grounds pursuant to N.J.S.A. 45:9-16 andN.J.S.A. 45:1-21(c), (d), (e) and (h) for the revocation or suspension of his license to practice medicine and surgery in this State.

At the completion of the Complainant's case in chief, some of the allegations in this count of the second Complaint were dismissed for failure to establish a prima facie case. The remaining allegations are that, during the time M.B. was in his care, respondent:

1. Failed to assure adequate dilatation prior to commencement of the extraction;
2. Failed to estimate the probable extent of the laceration upon examination an

hour after the procedure had been completed;
3. Inappropriately and prematurely ruled out uterine perforation;
4. Inappropriately attempted to repair the cervical laceration by applying silver nitrate;
5. Inappropriately waited approximately three hours after M.B. began hemorrhaging before transferring her to a hospital for immediate medical attention.

Based on these allegations, complainant further asserts that respondent grossly mismanaged the care of M.B. by:
1. Undertaking to perform a 26-week abortion in an office setting;
2. Failing to appropriately address the patient's prolonged abnormal bleeding;
3. Failing or refusing to transfer her to a nearby hospital for emergency treatment in a timely manner;
4. Failing to exercise reasonable medical judgment throughout his care of M.B.

The findings of fact which follow are derived from the credible evidence in the record. M.B. was a 20-year-old mother of one child who had called Dr. Brigham's office in Voorhees, New Jersey, to schedule an abortion. Because the information she provided indicated that she was well beyond 14 weeks LMP, M.B. was advised to call respondent's office in Spring Valley, New York, where second trimester abortions were performed. After letting considerable time pass, M.B. made an appointment and she and B.B., who is now her husband, went to respondent's office in Spring Valley, New York, on the afternoon of November 10, 1993. M.B. went through the customary steps of intake which included filling out various forms. She discussed her medical history form during intake counseling with nurse Wendy Jacquet, and her questions were answered. Dan De la Pena, M.D., introduced himself to the couple as a medical assistant. Although he is called "Dr. Dan," it is undisputed that Dr. De la Pena is not a licensed physician in the State of New York. He was a licensed physician in the Philippines, where he had substantial emergency room experience. He is now assistant administrator of an adult home in Rockland County, New York, and is studying for medical licensing in the United States. Dr. De La Pena did M.B.'s blood and urine testing.

M.B. then had a lengthy counseling session with Wendy Jacquet, and the two to three day procedure was explained in detail. M.B. was given a fact sheet which listed possible complications, including cervical laceration, uterine perforation, hysterectomy, and death. Dr. Brigham introduced himself to M.B. and he answered her questions about the risk of complications. He counseled her and she indicated she still wanted an abortion. Then, in the presence of B.B., she was examined by Dr. Brigham. He found on examination that M.B. had "a very long vagina, and her obesity made exam a little difficult." The cervix was noted to be " very short-lipped and with a long cervical canal" (emphasis in original) (P-22, page 4; also P-22, page 24). Dr. Brigham performed an ultrasound which revealed a single intrauterine pregnancy with a biparietal diameter of 61 millimeters, which corresponds to 26 weeks gestation on a Hobbins scale. He told the couple that he could do the abortion for M.B., and she continued to want the procedure after she and B.B. conferred.

Using ultrasound guidance, Dr. Brigham injected 1.5 milligrams of Digoxin into the amniotic fluid to effect a painless intrauterine fetal demise. He then inserted 12 eight millimeter laminaria into the patient's cervix. M.B. was then sent to the recovery room, where she was observed, given antibiotics, and instructed on what to expect that evening and when to return the next day.

The next morning, Dr. Brigham examined M.B. and noted that the 12 laminaria were in place and were swollen. After removing the laminaria, he was able to pass an 89 French Hern Dilator, so that he knew M.B.'s cervix was dilated at least three centimeters. Dr. Brigham inserted three fingers into her cervix, by which he estimated M.B.'s cervical dilation to be four to five centimeters. With this estimate, he decided to proceed with the abortion. He was assisted throughout by Michelle Smith, and in part by nurse M.F. and nurse Jacquet. An intravenous line was started and M.B. was given a paracervical and intracervical block. Her membranes were ruptured and the amniotic fluid was drained. M.B. was given conscious sedation, so she remained awake throughout the procedure.

Dr. Brigham performed a modified Dilatation and Evacuation procedure in his routine manner, and the procedure appeared to be normal. According to Dr. Brigham's record, the fetus dismembered easily, but there was some resistance in extracting the fetal skull. While performing the abortion, he noted that fetal skull plates were extruding from the side of the decompressed fetal skull. This was also normal for a termination in a pregnancy of this duration. Dr. Brigham did not feel there was anything unusual about the procedure, and M.B. was comfortable throughout. Dr. Brigham testified credibly that he did a visual vaginal inspection at the end of the abortion procedure. He did not observe M.B. to be bleeding. Dr. Brigham did not use instruments or maneuvers to manipulate the cervix, so an endocervical laceration was not visible to him at that time.

In fact, M.B. did have an endocervical laceration, which Dr. Brigham would later detect. It is more likely than not that as the fetal bones were being withdrawn through M.B.'s cervical canal during the course of the abortion, a sharp bone such as a skull plate lacerated the endocervical canal. It is also more likely than not that the sharp bone severed the uterine artery. There can be little doubt that the severed uterine artery must have spasmed quickly, retracted, and thrombosed, limiting the initial blood loss to an insignificant amount. Since bleeding is the evidence that an artery has been severed, confirmation of severance of the uterine artery could not come until an operative procedure was undertaken later at the hospital.

Following the procedure, M.B. seemed to be fine. Shortly after 11:00 a.m., she was able to dress and walk from the procedure room to the recovery room, pushing an I.V. pole, accompanied by B.B. and Michelle Smith. The events in the recovery room were established by the credible testimony of staff members and were even corroborated by L.P., another patient who was present. M.B. sat on a sofa in the recovery room and was attended by Dr. De La Pena. He monitored her vital signs regularly, and they appeared to be within the normal range. She had moderate bleeding, which was not unusual following a 26 week abortion. M.B. stayed awake, and was able to answer Dr. De La Pena's questions. She drank some juice and ate some cookies. She was able to stand and walk unassisted to the bathroom at about 12 o'clock.

At about 12:15 p.m., Dr. De La Pena noticed some blood on the pad on which M.B. was sitting, and he asked a staff member to have Dr. Brigham come to the recovery room. Dr. Brigham arrived and had M.B. stand. When she stood, 100 to 200 cc of blood came out of her vagina and pooled on the floor, frightening the patient. She became very unsteady, but was not disoriented. Drs. Brigham and De La Pena had her sit in a chair with wheels, and they wheeled M.B. back into the procedure room at about 12:20 p.m..

Dr. Brigham was alarmed by the blood loss; it was not normal. His first concern was to assess the patient's hemodynamic stability to see if she was stable enough for further evaluation in the office. Upon examination, Dr. Brigham found M.B.'s vital signs to be within the normal range. While the amount of blood loss was not typical, and was clinically significant, Dr. Brigham did not consider it to be hemodynamically significant. M.B. was awake and alert, but frightened and confused by the situation. She was pale, but not ashen or cyanotic, and she showed no signs of shock. Dr. Brigham noted blood clots, making disseminated intravascular coagulopathy unlikely. While bright red blood would indicate fresh arterial bleeding, M.B.'s blood was dark red, meaning it had accumulated. There was no clinical evidence of hypovolemia. M.B. was dripping blood at a steady rate of about 2 cubic centimeters a minute, and was not spurting. This was not a dangerous rate of blood loss.

Present in the procedure room throughout the rest of the afternoon were nurse Jacquet, Michelle Smith, Elizabeth Navarra, Dr. De La Pena, and Dr. Brigham. Ms. Navarra and Ms. Smith were directly assisting Dr. Brigham at the foot of the table. Ms. Jacquet and Dr. De La Pena were at the head of the table. She was measuring M.B.'s vital signs and taking timed notations of events on table paper, while Dr. De La Pena was talking to the patient and comforting her, while monitoring her

intravenous fluids.

At 12:30 p.m., Dr. Brigham measured the patient's vital signs in the supine and sitting positions and these measures confirmed that she had not lost a significant blood volume, and she was sufficiently stable to continue evaluation. Her pulse oximeter readings were fine. Respondent decided to continue to examine and observe M.B., and considered that he would transport her to the hospital immediately if her clinical course deteriorated or if her problem required admission (P-22, page 7).

When respondent examined M.B. at 12:30 p.m., he detected a two to three centimeter endocervical canal laceration (P-22, page 7). His notes state that the laceration extended into the cervical canal; they do not indicate that the laceration extended beyond the canal. Dr. Brigham testified sincerely and credibly that if the laceration had extended beyond the cervical canal, he would have put that information in his notes. While the notes also do not state how he detected the presence of the laceration, it was also Dr. Brigham's sincere and credible testimony that he detected the laceration first by palpation and then by visualization. He stated that he could feel both ends of the laceration. He inserted a speculum in M.B.'s vagina and used Hanson's Maneuver to bring the cervix closer to his hand and eye. He could then see that the laceration was two to three centimeters long. He could see both ends, and the laceration did not extend into the lower uterine segment. Dr. Brigham noted its location as about 10 o'clock in the cervical canal.

The cervical laceration by itself did not indicate that M.B. would require hospitalization. It was a small cut. Dr. Brigham was concerned that there might be internal bleeding that he was not seeing, but all the vital signs still indicated that the patient was not hemodynamically unstable. He wanted to test for and rule in or rule out the possible diagnoses. At about 1 p.m., Dr. Brigham took a curette (Exhibit P-43) and gently scraped along the edges of the uterus. He did this to make sure the uterus was empty of the products of conception and to feel for discontinuity of the surface, indicating a uterine perforation. Dr. Brigham testified credibly that he was careful to not go near the cervical laceration with the curette. He did not find a uterine perforation and felt that it was likely ruled out.

At about 1:10 p.m., Dr. Brigham performed a transabdominal ultrasound to look for internal bleeding, but he detected none using this technique. Next, he applied silver nitrate to cauterize any small blood vessels that were bleeding. This can aid visualization of the operative field. He was not attempting to repair the laceration with silver nitrate. He showed the cervical laceration to Michelle Smith and Elizabeth Navarra. M.B. was still clinically stable, and there was no evidence of internal bleeding. A slight fall in her hematocrit was consistent with the observed blood loss. At that point, Dr. Brigham decided that M.B. was sufficiently stable for him to attempt to suture the cervical laceration. He hoped to be able to suture the apex of the laceration.

M.B. was awake and alert during the entire suture effort. With his assistants pushing on the fundus of the uterus and pulling on the cervical lip, Dr. Brigham was able to appose the edges of the laceration and secure it with one suture in the center of the laceration. He then abandoned the attempt to place any further sutures. It was Dr. Brigham's credible testimony that the apex of the laceration had not extended during the suture effort. The chart states, "1:50 p.m.... Abandoned attempt to suture cervix. Difficulty in suturing cervix was threefold: 1) Pt has a very long cervical canal which makes it difficulty to reach the cervix, 2) Pt is obese. Due to obesity lateral vaginal walls obscured cx. 2nd speculum used. 3) The patient has a very small external cervix. All of these combined together to make transvaginal repair of Cx difficult." (P-22, pages 10-11).

At 1:58 p.m., Dr. Brigham observed that M.B. was not bleeding from her vagina. There was no indication from her vital signs that she had internal bleeding. Her hematocrit readings were completely consistent with the external bleeding which had been observed. Between 2:00 and 2:30 p.m., Dr. Brigham was the most confident that there was no internal bleeding. He and his assistants continued to monitor M.B.'s

vital signs. Her blood pressure was steady and consistent with her preoperative readings. Her oxygen saturation was fine. Dr. Brigham gave M.B. some oxygen, but she did not like it and it was removed.

At 2:30 p.m., M.B. urinated 200 cc. of clear urine, indicating that she was not hypovolemic. She was not bleeding from her vagina, and she was neither diaphoretic nor cyanotic. There was no reason at that time to transfer M.B. to the hospital. However, she soon thereafter took a turn for the worse. It is more likely than not that around 2:35 p.m., the severed and thrombosed uterine artery began to bleed again, due to disintegration of the blood clot. Dr. Brigham began to observe subtle changes, which were signs that M.B. might be bleeding internally. There was mild tachycardia, which was nonspecific, as it can be caused by a variety of conditions, including anxiety or cramping. Dr. Brigham again gave M.B. a complete examination. It was significant to him that M.B. was passing gas, as this indicated she had peristaltic function. Her blood pressure was at 70/50 and her pulse was at 104.

By 2:40 p.m., Dr. Brigham noted M.B.'s blood pressure was at 80/50, her pulse was elevated to 112, and she was pale but not ashen or cyanotic. She was woozy although awake and talking. At 2:45 p.m., M.B.'s blood pressure was still at 80/50, but her heart rate had risen to 115. From 2:35 until 2:55 p.m., five sets of vital signs were recorded. Her oxygen saturation was fine, and her blood pressure was fine, too. However, at 2:55 p.m., M.B. sat up and felt dizzy, and blood came out of her vagina. This was evidence of additional bleeding, but she was not in shock. Also at 2:55 p.m., M.B.'s hematocrit reading was at 18 percent. It had dropped eleven points in 15 minutes. This was significant and was the first moment that M.B.'s internal bleeding was diagnosable. Dr. Brigham knew then that he could not handle the patient himself in his office and he called for an ambulance. Knowing then that M.B. would need a transfusion and surgery, Dr. Brigham called the Nyack hospital and explained the situation to Dr. Rausch, the emergency room physician. He also called the office of the surgeon, Dr. Jakus, and asked that he be paged at he hospital and given the necessary information. He did not utilize his backup agreements with area physicians, choosing instead to have M.B. admitted through the emergency room.

While waiting for the Emergency Medical Service ("EMS") to arrive, M.B. was not in frank, overt shock. She was hemodynamically stable, and continued to be so after the EMS arrived. The EMS personnel included Jeff Rabrich and John White. Although they testified in essence that M.B. was confused, lethargic, pale and agitated, they scored M.B. at 13/15 and later 14/15 on the Glascow Coma Scale. These were essentially normal scores, implying that M.B. was awake and not disoriented. None of the paramedics or emergency medical technicians checked off "shock" on the Prehospital Care Report (Exhibit P-22, pages 41 to 43). The patient's cool and dry skin noted by the paramedics also indicated that she was not in shock. The paramedics were apparently not in a rush. The spent 16 minutes at Dr. Brigham's office without doing anything of therapeutic value, indicating there was a lack of urgency in the situation. The vital signs they recorded were essentially consistent with the vital signs record earlier by Dr. Brigham's staff.

Dr. Brigham went to the hospital with M.B. in the ambulance. She was awake and talking on the trip, and complained about the bumpy ride. She was able to give oral informed consent at the hospital for surgery although she was unable to sign a written consent form. The triage nurse described her as "AA+O (awake, alert and oriented), skin extremely pale." (P-22, page 38). Her temperature upon arrival in the emergency room was 96 degrees, with a pulse of 113. Her blood pressure, which had been 90/60 before the abortion, was 88/52. Thus, the vital signs taken in the doctor's office, the vital signs taken by the EMS, and the emergency room vital signs, were all consistent with each other, and consistent with a uterine artery that was not actively hemorrhaging.

Dr. Brigham explained to the emergency room nurse what had happened and what he had done, and said that he felt M.B. needed a blood transfusion and surgery. However, M.B. was not immediately given a transfusion, and blood was not drawn from her for about one-half hour after she arrived. The emergency room physician, Dr. Rausch, noted that M.B. was alert and mentating. He went on to examine other

patients after he examined M.B., which indicates that she was not in hypovolemic shock. At 4:30 p.m., the hospital laboratory called in the results of the hematological blood tests. It is more likely than not that the lab results were in error because the blood sample was drawn downstream from the I.V. containing five percent dextrose. Lab values included nine percent hematocrit and a serum glucose level of 726. The hospital hematologist later noted that the decreased hematocrit was likely the result of the dilutional effect on the blood sample. Even though the erroneous test result prompted M.B.'s discharge from the emergency room to the operating room at 4:30 p.m., she was noted to be in "good" condition at that time. Dr. Rausch noted that M.B. had a small, supercervical tear, palpable to his vaginal exam.

While the preop report indicates M.B.'s color was "ashen" (Exhibit P-22, page 48), it is more likely than not that M.B. was not in frank shock when she was brought to the operating room. Prior to surgery, the surgeon took an oral informed consent from M.B., indicating that the surgeon must have felt she was alert, oriented and competent to give consent. She was placed under general anesthesia and examined in the operating room, starting at 4:30 p.m., but it was not until about 5:05 p.m. that the first blood transfusion was given. Also indicating that M.B. was not in hypovolemic shock, the surgeons first attempted to repair the cervical laceration from below. 45 minutes were spent examining, suturing, and monitoring the patient while she was anesthetized, before surgery began.

At 5:15 p.m., the surgeons opened M.B. with a small incision. There was no damage to the mesosalpinx noted by the surgeons, and no blood was noted in the abdomen. The uterine artery was found severed and retracted and thrombosed in the retroperitoneal cavity, and that cavity held about 350 c.c.s of blood and clots. A total abdominal hysterectomy was performed, with M.B.'s normal ovaries left in place. Dr. Jakus reported that M.B. had a one centimeter perforation in the low uterine segment as well as a cervical laceration of four and one-half to five centimeters extending into the lower uterine segment almost at the level of the arrival of the uterine artery from the lateral areas, and he opined that this "was probably the reason for the severance of the uterine artery." However, the surgical pathologist, Dr. Susan Jormack, examined M.B.'s uterus and she did not confirm the presence of a four to five centimeter laceration extending into the lower uterine segment.

Dr. David Hollander testified that he has studied M.B.'s medical records. It was his opinion that it was not within the generally accepted standard of care for Dr. Brigham to commence a 26 week abortion in his office setting because the risk to the "mother" and her cervix of infection and perforation of the uterus is greater. If a complication occurs, the physician should have back up mechanisms and personnel in place to handle the increased risk. As a pregnancy increases in duration, the fetus becomes bigger, so greater dilatation of the cervix is required for the evacuation. The fetus' head is bigger, so the skull may need to be fractured and decompressed to remove it. In addition, the uterus is bigger, softer, and easier to tear. In short, the bigger the "baby," the more difficult the procedure, according to Dr. Hollander.

Dr. Hollander opined that the degree of risk was even greater for M.B., because she had a very long vagina; she was obese, so the cervix was harder to see; and her cervix was short lipped so it was harder to grasp. He felt these anatomical features made M.B. a harder patient to deal with if there were complications. According to Dr. Hollander, the physician must decide at the time of the preop consultation how difficult the surgery will be and so choose the appropriated setting. He described M.B. as a patient whose abortion should have been done in an in-patient facility.

It was the testimony of Dr. Hollander that Dr. Brigham, upon detecting the cervical laceration following the abortion procedure, should have first found its apex and sutured it to stop the bleeding, before doing anything else. He felt that other procedures, such as curetting the uterus, would by manipulation tend to make the cervical tear dissect upwards further, toward the uterus. According to Dr. Hollander, this would endanger other organs and make the cervical tear harder to

repair. Dr. Hollander concluded from the medical records that no suture was actually placed, and he opined that Dr. Brigham should have transferred the patient to a facility that could accomplish the suture, since he had determined it should be done but could not do it.

Significantly, Dr. Hollander did not interpret Dr. Brigham's description of the laceration of "extending into the cervical canal" to mean that the laceration went beyond the cervical canal. He also did not believe that the uterine artery laceration was present at the time the initial abortion procedure terminated. It was his opinion that the laceration continued to extend upward on subsequent manipulation. Dr. Hollander also noted that a two centimeter cervical laceration is not unusual on childbirth, and that often a physician would not suture such a laceration and it would heal on its own.

Dr. Hollander concluded from the test results of the first blood sample drawn from M.B. at the hospital that she was going into hypovolemic shock. He opined that Dr. Brigham had unduly delayed transporting M.B. to the hospital, and that this delay had an adverse impact. He felt that M.B. developed D.I.C., making surgery more difficult, and that the change in M.B.'s vital signs indicated that the laceration was getting worse. It was Dr. Hollander's opinion that Dr. Brigham's decision to undertake this patient's care and his overall management of the case did not comport with generally accepted standards of care. He considered the deviation from standards to be high, with the strongest deviation being the failure to immediately suture the bleeding cervical laceration.

Dr. Nicholas Kotopolous testified that it is important to achieve adequate dilatation of the cervix for late second trimester abortions because of the large fetal parts coming through the cervix. In his opinion, two days dilatation or more generally should be provided for termination of a 25 or 26 week pregnancy. He stated that one insertion of laminaria and completion of the abortion procedure the next day is not the standard of care, and he concluded that patient M.B. was inadequately dilated. In particular, Dr. Kotopolous had difficulty believing that Dr. Brigham had inserted 12 eight millimeter laminaria at one sitting. In his opinion, Dr. Brigham should not have handled M.B.'s procedure in his office.

Dr. Kotopolous testified that when Dr. Brigham encountered resistance in extracting the fetal skull, he should have realized that the cervix was only partially dilated. He noted that here is a great likelihood of injury to the uterine artery from the bony fetal skull coming through an inadequately dilated cervix. While a lacerated cervix can be repaired in the office if its extent can be determined, a ruptured uterine artery must be repaired by laparotomy in the hospital. Interestingly, it was Dr. Kotopolous' opinion that Dr. Brigham saw the cervical laceration at the end of the original procedure and that he deviated from the generally accepted standard of care by sending M.B. to the recovery room without making an appropriate diagnosis. According to Dr. Kotopolous, at 12:30 p.m. when Dr. Brigham says the cervical laceration was detected, the indications were that something was very wrong, and Dr. Brigham should have then taken M.B. to the hospital rather than monitoring her in his office. In his opinion, the hysterectomy could have been avoided if Dr. Brigham had timely transferred M.B. to the hospital. Dr. Kotopolous characterized Dr. Brigham's efforts as acts of desperation, and he opined that M.B. was in a life threatening situation by the time she reached the hospital. In Dr. Kotopolous' opinion, respondent deviated grossly from the accepted standards of care.

Dr. Michael Policar testified that neither New York nor California require that late second trimester abortions be performed in hospital settings. He said that there is no medical reason requiring that all such procedures be done in hospitals, and while some patients' conditions dictate hospital care, the reality is that most of the procedures are done in an office setting, consistent with good standards of care. Dr. Policar acknowledged that most Planned Parenthood clinics put an upper limit on abortions at 20 weeks, but that relatively conservative limit was due to self-insurance and legal protection concerns, and not because of ethical or medical considerations.

Dr. Policar reviewed the records concerning M.B. and concluded that the office setting was appropriate for her abortion procedure. He noted that the insertion of 12 eight mm. laminaria was both medically possible and consistent with generally accepted standards of care. He has himself inserted this many and more in patients with late second trimester abortions. In addition, insertion of laminaria a day or two in advance of evacuation of the uterus is customary, common, and in accordance with generally accepted standards of care. Dr. Policar opined that insertion of laminaria does not constitute an abortion; they can be removed and the pregnancy can proceed to term. He feels insertion of laminaria is an abortion procedure, but it is not equivalent to an abortion itself.

It was the opinion of Dr. Policar that M.B.'s cervix was adequately dilated. Because Dr. Brigham was able to pass an 89 French Hern dilator, the cervix was dilated at least 3 centimeters. Three fingers (Exhibit P-22) generally is 5 cm., which would be more than adequate for commencement of the abortion procedure. According to Dr. Policar, using two measures of dilatation showed good judgment and procedure.

Dr. Policar testified that following the evacuation of the uterus, the physician should visually inspect the cervix for a laceration or bleeding, as Dr. Brigham did. Insertion of a finger into the cervix would not normally be done, avoiding more uterine contamination from bacteria. In Dr. Policar's opinion, M.B.'s endocervical laceration would not be observable upon visual inspection. Dr. Brigham had no reason to expect excessive cervical bleeding or an endocervical laceration, and his actions comported with generally accepted standards of care. M.B. was properly monitored following the procedure, in Dr. Policar's opinion. When subsequent bleeding was assessed, M.B. was returned to the procedure room and an endocervical laceration was then identified. Dr. Policar testified that there is no indication that Dr. Brigham failed to estimate the probable extent of the laceration. Consistent with good practice, Dr. Brigham also went through an extensive list of possible causes of bleeding.

Dr. Policar opined that the greatest proportion of M.B.'s blood loss was from laceration of the uterine artery. He has experience managing uterine artery lacerations occurring as complications in abortions, which he noted is an unusual but well known complication of a well-performed abortion. It occurred once in an abortion performed by Dr. Policar, and the laceration was caused by a piece of fetal skull. His patient was transferred to the emergency room and an abdominal hysterectomy was performed.

Dr. Policar testified as to every step in the course of Dr. Brigham's handling of M.B., and he believes Dr. Brigham appropriately addressed her bleeding. He properly stabilized the patient and attempted to suture the cervical laceration, consistent with generally accepted standards of care. There was no emergency that required the patient's immediate transfer to the hospital. It was Dr. Policar's opinion that every step in the procedure and the pattern of care show that Dr. Brigham properly observed and monitored M.B., and exercised reasonable medical judgment. Dr. Policar testified persuasively that the appropriate standard of care was provided at every step, and that Dr. Brigham's management of M.B. was also in accord with national standards for these practices. In Dr. Policar's opinion, there was no gross negligence, nor repeated acts of negligence, nor any negligence in Dr. Brigham's handling of this patient.

Dr. A.K., who was appointed to serve as Dr. Brigham's monitor, testified that he performs abortions in New York State up to the legal time limit. It is permissible and the accepted practice that such abortions are done there in the doctor's office. Some doctors advertise this service. Dr. A.K. testified that he reviewed M.B.'s chart, and it was opinion that there was nothing about her LMP, vagina size, or cervical size that had any bearing on having the abortion procedure done in the doctor's office. Similarly, M.B.'s height and weight were not factors having a bearing on whether or where the procedure was done. According to Dr. A.K., what really matters is being able to see and grasp the cervix, and being able to insert laminaria. In this case, the critical factor was satisfied because the insertion of twelve laminaria indicates Dr. Brigham was able to see and grasp the cervix.

Dr. A.K. testified that he has performed abortions in the office setting for patients at 26 weeks who were obese and had long vaginas and short cervical lips. This was consistent with the generally accepted standard of care. He determines the adequacy of dilatation by removing laminaria, grasping the cervical lip with forceps, and inserting forceps requiring about 2 centimeters' diameter. If necessary, he will insert progressively larger dilators to achieve an opening sufficient for insertion of the forceps. In his opinion, four to five centimeters is more than enough dilatation, and three fingers of dilatation is closer to six centimeters' dilatation. Dr. A.K. testified that the size of M.B.'s cervix and vagina did not affect the amount of dilatation required.

Dr. M.A.B. testified that it is not inappropriate to perform a 24 to 26 week abortion in a doctor's office if the doctor has experience. He was familiar with Dr. Brigham's reputation as an abortion provider, and he stated that from all reports he had, Dr. Brigham was technically excellent, with a very low complication rate. In Dr. M.A.B.'s practice, he has had occasion to deal with cervical lacerations. In his opinion, a two centimeter laceration is not large, and the mere occurrence of a cervical laceration does not require transferring a patient to the hospital. In fact, the vast majority of lacerations do not even require suture. With a two to three centimeter cervical laceration, it would be appropriate to observe the patient and monitor vital signs before attempting to suture the laceration. This would not be altered if a patient is obese, with a long vagina and a short cervix.

Dr. Anthony Mustalish reviewed M.B.'s records (Exhibits P-22a to c). He noted that it is not unusual to have a health care worker take notes on table paper or even a bed sheet. The intention is that the recorded data and key events would then be taken so that a narrative and formal record of salient events could be prepared. In his opinion, it is completely proper for a nurse to monitor and record vital signs, and for the physician to rely on the data later to write the definitive note in the report. The physician must wait for the next best opportunity to write the report, which might be the next day, or even within a week. Since Dr. Brigham had accompanied M.B. to the hospital, it was in accord with generally accepted standards of care for him to write his record the next day.

Dr. Mustalish disagreed with the opinion that M.B. should have been immediately transported to the hospital upon discovery of the cervical laceration. In his opinion, to a reasonable degree of medical certainty, the patient record for M.B. reveals that it was not necessary to transport her to the hospital prior to the time Dr. Brigham took that action. The patient's normal and routine parameters used to evaluate her condition had no significant changes until just before 3:00 p.m., so until then, she was stable.

According to Dr. Mustalish, the physician must first assess the size and shape of a cervical laceration and the amount of bleeding, and must monitor the patient's vital signs. Dr. Mustalish testified that it would be appropriate for a physician to place one stitch in the center of a one or one and one-half inch cervical laceration, if the edges were apposed. Since silver nitrate coagulates bleeding, its use may help visualize the laceration and would be consistent with generally accepted standards of care. Bleeding of the cervical laceration contributed only a minor blood loss, while a lacerated uterine artery could rapidly result in major blood loss. Given M.B.'s stable vital signs over several hours, Dr. Mustalish concluded that the patient's uterine artery went into spasm and thrombosed, therefore not contributing to significant blood loss. Significantly, Dr. Mustalish opined that the uterine artery laceration was not a clinically diagnosable situation; it could only be discovered operatively.

It was Dr. Mustalish's opinion that Dr. Brigham's management of M.B., including continuous observation, monitoring, control of bleeding, and diagnostic measures, was in accord with generally accepted standards of care. Because of his compulsive attention and patience in monitoring M.B., Dr. Brigham was able to pick up a subtle clinical change in her condition, and he immediately arranged for her transport to the hospital.

Dr. Mustalish noted that the EMS paramedics were at Dr. Brigham's office for 16 minutes. He said this would be considered a long time if M.B. had been in any extremis, and it indicated her condition was not so urgent as to require a "scoop and run" approach. He also noted that the paramedics took no significant intervention measures, and did not check off on their form that M.B. was in shock. Her presenting condition indicated that she was not in shock. The Glasgow Coma Scale was used to describe M.B.'s level of consciousness, and it indicated she was awake and not disoriented. She was not in shock on the way to the hospital.

It was Dr. Mustalish's opinion that Dr. Brigham acted consistently with generally accepted standards in providing continuity of care. He called ahead to the hospital and provided the information the hospital would need, and he rode to the hospital with the patient. It is normal for hospitals to treat patients of physicians who do not have admitting privileges. This particularly applies to out-patient abortion procedures, where patients may travel great distances for the procedure. When M.B. arrived at the emergency room, there were emergency concerns, but she was stable. That the hospital did not immediately give her universal donor blood and waited about one-half hour to draw her blood indicates that it was a routine handling and that M.B. was not in shock upon arrival. It was Dr. Mustalish's opinion that Dr. Brigham's records, the EMS records, and the hospital records, all indicate that M.B. was a stable patient. He believes that Dr. Brigham's exercise of medical care and judgment was good, to a reasonable degree of medical certainty, and consistent with generally accepted standards of care. Dr. Mustalish was sincere and candid. He was an impressive witness.

Dr. Brigham testified that upon seeing the cervical laceration, it would not have been appropriate to rush M.B. to the hospital. The rate of blood loss of about two cc per minute was not dangerous. The laceration was a small cut which did not extend into the lower uterine segment, contrary to Dr. Kotopolous' opinion, and there was no indication from the cervical laceration alone that hospitalization would be required at all. Dr. Brigham testified that he totally disagreed with the opinion of Dr. Hollander that the first thing he should have done was to suture the laceration. It was Dr. Brigham's opinion that he first needed to rule out any life threatening causes, and the cervical laceration was low on the list of concerns to check out. His biggest concern was internal bleeding. He was worried that M.B. might be bleeding at some undetectable rate into the abdominal cavity, but all the vital signs indicated there was not hemodynamic instability. If he had thought there was a uterine perforation, he would have hospitalized M.B. immediately, since he could not repair that in the office.

DISCUSSION

Complainant contends that M.B. was a high-risk patient for an abortion in an out-patient setting. The reason she was high risk were that she was undergoing a 26-week abortion and the risks attendant to abortion increase with each passing week; she was obese; and respondent found her to have a very long vagina, long cervical canal and short cervical lip. Complainant argues that given the greater likelihood of encountering problems, which respondent should have anticipated, he should have referred her to have the procedure done at a more appropriate facility. Referral to another practitioner for an abortion by induction was one alternative that would have been available in this case. Referral of the patient to a practitioner who would perform this procedure in a hospital or clinic facility was another alternative that would have been available and prudent in this case.

By the time respondent completed M.B.'s 26-week abortion, her cervix had been lacerated. Complainant argues that this may have been due in part to inadequate dilatation of M.B.'s cervix. Complainant notes that respondent did not begin an attempt to suture the bleeding cervical laceration until 1:20 p.m. He worked on it for one-half hour and then abandoned this attempt, citing the anatomical difficulties he'd found at the initial examination the previous day as the reason. The chart states, "1:50 p.m.... Abandoned attempt to suture cervix. Difficulty in suturing cervix was threefold: 1) Pt has a very long cervical canal which makes it

difficulty to reach the cervix, 2) Pt is obese. Due to obesity lateral vaginal walls obscured cx. 2nd speculum used. 3) The patient has a very small external cervix. All of these combined together to make transvaginal repair of Cx difficult." (P-22, pages 10-11). Complainant contends that a plain reading of this chart suggests that no stitches were placed and that the foregoing three points were the reasons for abandoning the attempt to suture the bleeding cervical laceration.

Complainant also contends that respondent did not truly estimate the probable extent of the laceration an hour after the procedure had been completed. His note does not state that he ascertained the upper apex of this laceration, whether by palpation or by sight. Knowing where the apex is and thus whether the laceration extends up into the lower uterine segment is quite significant. Complainant asserts that if respondent actually did ascertain the full extent of this laceration, it would have been to his benefit to note this fact in his chart, for it might justify his actions that afternoon.

Complainant contends that promptly suturing that laceration was the indicated procedure assuming respondent could diagnose the full extent of the laceration. Instead, he embarked on other diagnostic examinations such as curetting for retained products, and ultrasound. Complainant argues that an unsutured cervical laceration can extend upwards toward the lower uterine segment similar to a hem ripping, if there are manipulative procedures, such as curetting when using a weighted speculum. The chart reflects use of a "2nd speculum" during the suturing and respondent described using a "weighted speculum".

Complainant argues that if a patient is bleeding internally, rapid deterioration can set in even in a young healthy patient who has been able to compensate well for blood loss (Exhibit P-66). The physician therefore must take into account the likely lag time which may occur once he calls for emergency help. Respondent did not contact any backup physician or send the patient to the hospital at the point when he knew he had not sutured the apex of the cervical laceration. Rather, he continued to monitor her in his office, purportedly because her vital signs were stable, the external bleeding had stopped, and he did not see anything wrong with her condition. When there is significant internal bleeding, blood moves from the extremities to the heart and internal organs. Complainant contends that the patient's growing pallor could have signaled significant problems, and would have occurred over the course of the afternoon, not just in the least 10 minutes.

The respondent contends that Dr. Hollander's testimony is called into question because of bias and lack of scientific understanding of procedures, as well as medical errors. Respondent points out that Dr. Hollander's subspecialty is in Perinatology, and his training and allegiance are directed toward delivering 26 week fetuses. He has not performed elective abortions past 18 weeks; the vast majority have been for genetic problems with the fetus. Dr. Hollander has never actually performed a D&E procedure on any patient as late as either J.K., A.W., or M.B., and he has never performed a second trimester abortion on an outpatient basis. In his entire career, most of the abortions he has done in the hospital were done via the induction method. Dr. Hollander is not a member of the National Abortion Federation, although he has some familiarity with their published Standards of Care.

Respondent contends that Dr. Hollander made fundamental errors in anatomy and sonography, such as Dr. Hollander's assertion in his rebuttal letter (Exhibit P-66) that the uterine artery is not in the retroperitoneal cavity, and therefore, one would not see primarily a retroperitoneal bleed. As stated by Dr. Fogel, Dean of Mount Sinai Medical School, in his reply to Dr. Hollander's assertion (Exhibit R-68), "Clearly, the uterine artery and most of the gynecological organs, their blood and nerve supply are all retroperitoneal. Indeed, the surgical findings in this case similarly describe a thrombosed uterine artery in the retroperitoneal space." Dr. Burnhill similarly found fault in Dr. Hollander's knowledge of anatomy (Exhibit R-67). He said, "This statement is anatomically wrong. The uterine artery is retroperitoneal. Furthermore, the surgeons in this case found M.B.'s uterine artery in the retroperitoneal cavity. Therefore, one would expect to see primarily a

retroperitoneal bleed in M.B.'s case. In fact, this is what the surgeons saw at Nyack Hospital." Dr. Burnhill did not mince words. His rebuttal letter concludes:

> Dr. Hollander's assumptions and ideas are anatomically and physiologically inaccurate. This includes errors as to how arteries can thrombose, and even more surprisingly, mistakes as to the simple anatomy of the main blood supply to the uterus. It is difficult to understand how Dr. Hollander, a board certified and practicing Perinatologist, could not know the anatomy of the uterus and its blood supply. Someone who is specifically trained in gynecological surgery, and who has devoted his career to his specialty of preserving and delivering healthy 24 and 26 week fetuses, should be an expert in the anatomy of the uterus. Yet his statement contains basic and glaring errors. In fact, his statement is so medically inaccurate that it raises the question of whether his rebuttal letter was accidentally imprecise or intentionally misleading. Regardless, nothing contained within Dr. Hollander's letter changes my view that Dr. Brigham's care and treatment of the J.K. and M.B. cases was well within acceptable standards of care.

Respondent contends that it was an appropriate and reasonable exercise of his medical judgment to undertake to perform M.B.'s abortion procedure in his well-equipped New York office, and he points to the substantial expert opinion he presented in support of this position. The credible evidence establishes that he achieved adequate dilatation for performance of the abortion by insertion of 12 laminaria, notwithstanding the opinion of Dr. Kotopolous. Respondent further contends that he properly estimated the probable extent of the laceration, and his credible testimony on this subject was confirmed by the credible testimony of his assistants who observed the laceration. Significantly, while Dr. Kotopolous opined that Dr. Brigham had misdiagnosed the extent of the laceration, the complainant's other expert, Dr. Hollander, did not share that opinion.

Respondent further contends that the evidence does not establish that he inappropriately and prematurely ruled out uterine perforation, as asserted by only Dr. Kotopolous. He properly checked for uterine perforation and detected none, but there is no evidence to suggest he ruled it out. Respondent also contends that the evidence establishes that he did not attempt to repair the cervical laceration by applying silver nitrate. Rather, the silver nitrate was used to cauterize small blood vessels in preparation for repairing the laceration, and the experts agree that such use was appropriate.

It is respondent's position that he appropriately addressed M.B.'s bleeding, and that he did not fail to timely transfer M.B. to the hospital. He palpated and observed the extent of the cervical laceration, and then appropriately assessed the patient's stability and ruled out life-threatening diagnoses prior to attempting to suture the laceration. Respondent asserts that Dr. Hollander's opinion that this course constitutes negligence is unreasonable and contrary to the testimony of numerous experts who supported Dr. Brigham's care and treatment of this patient. In addition, respondent notes that Dr. Hollander and Dr. Kotopolous disagreed about, among other things, whether the laceration should even be sutured in the office at all. Respondent contends that he carefully monitored and observed M.B., and he timely transferred her to the hospital when her clinical picture began to change, as Dr. Mustalish emphatically agreed. Thus, respondent contends that he properly exercised reasonable medical judgment throughout his care of this patient.

I agree with the respondent's contentions. The complainant has failed to meet her burden of persuasion. The respondent was a sincere and credible witness on his own behalf, and the expert testimony in support of his competence and adherence to the generally accepted standards of care was impressive and persuasive. I FIND that respondent properly undertook performance of M.B.'s 26- week abortion in his office setting, which was appropriately equipped and well-staffed. I FIND that respondent properly assured adequate dilatation prior to commencement of the extraction, and he properly ascertained the extent of the cervical laceration upon examination an hour after the procedure had been completed.

I further FIND that respondent did not inappropriately and prematurely rule out uterine perforation, and he did not attempt to repair the cervical laceration by applying silver nitrate. I FIND that respondent appropriately addressed the

patient's abnormal bleeding, and that he appropriately transferred her to a nearby hospital for emergency treatment in a timely manner. In summary, I FIND that respondent exercised reasonable medical judgment throughout his management of M.B., in accordance with generally accepted standards of care.

Based upon the foregoing, I further FIND that respondent Brigham's conduct concerning patient M.B. did not constitute gross or repeated acts of negligence, malpractice or incompetence, nor professional misconduct. He did not endanger M.B.'s life and he did not exercise medical judgment contrary to the safety and well-being of the public of this State. Thus, I CONCLUDE that respondent's conduct concerning M.B. did not constitute grounds pursuant to N.J.S.A. 45:9-16 and N.J.S.A. 45:1-21(c), (d), (e) and (h) for the revocation or suspension of his license to practice medicine and surgery in this State .

Alleged Record Keeping Violations

Alteration of Records (Amended Complaint, Counts IV (S.C.) and V (B.A.))

Failure to Maintain Accurately Identified Sonograms (Amended Complaint, Count VII)

Failure to Maintain Records of Intraoperative or Postoperative Vital Signs (Amended Complaint, Count VIII)

Complainant alleges at Count IV of the Amended Complaint that respondent failed to accurately assess the status of S.C.'s pregnancy, performed an abortion in his office at a point later than 14 weeks LMP, intentionally or negligently altered his medical chart for S.C. by removing a portion of the chart, or maintained an inaccurate record by placing someone else's sonogram into S.C.'s chart. Based on these allegations, Complainant contends that respondent Brigham was negligent and engaged in conduct which violates N.J.A.C. 13:35-4.2 and -6.5. Complainant further contends that this alleged conduct constitutes grounds for the revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d) and (h), and when taken in combination with conduct alleged in other counts, constitutes repeated acts of negligence, malpractice or incompetence, therefore constituting grounds for the revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d).

Complainant alleges at Count V of the Amended Complaint that with regard to patient B.A., respondent performed an abortion in his office at a point later than 14 weeks LMP, and intentionally or negligently altered his medical chart for the patient. Based on these allegations, Complainant contends that respondent Brigham engaged in conduct which violates N.J.A.C. 13:35-4.2 and - 6.5, and has engaged in the use of dishonesty, deception, or misrepresentation, as well as professional misconduct. Complainant further contends that this alleged conduct constitutes grounds for the revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:9-16 and N.J.S.A. 45:1-21(b), (e) and (h), and when taken in combination with conduct alleged in other counts, constitutes repeated acts of negligence, malpractice or incompetence, therefore constituting grounds for the revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d).

At the completion of the Complainant's case in chief, some of the allegations in Count VII of the Amended Complaint were dismissed for failure to establish a prima facie case. The complainant's remaining allegation in this count is that the sonograms in respondent's charts for dates prior to October 1993 were not identified with the patient's name or the date and in some instances bore little correlation to the other information contained in the patients' charts. Complainant alleges that the respondent has thus engaged in repeated acts of negligence and in professional misconduct, constituting grounds for the revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d), (e) , and (h). Complainant alleges at Count VIII of the Amended Complaint that patient records for abortion procedures performed prior to October 1993

reviewed at respondent's office did not reflect intraoperative or postoperative monitoring of vital signs. Complainant asserts that the failure to record and failure to monitor a patient's recovery following an abortion constitutes professional misconduct and repeated acts of negligence. According to the complainant, this conduct constitutes negligence and violates N.J.A.C. 13:35-6.5, and therefore constitutes grounds for revocation or suspension of respondent's license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d) and (h).

The findings of fact which follow are derived from the credible evidence in the record. On September 15, 1993, Investigators Mary Peterson, Deborah Zuccarelli and John Czuba went to respondent's office, accompanied by Lt. Keith Hummel of the Voorhees Police Department, to impound D.V.'s record and to review other charts. According to Ms. Peterson, before they began reviewing the charts they had a discussion with respondent about whether Medicaid or Medicare records were kept separately. She said that he assured them that all records for each patient were in those file cabinets and that was all the records he had in the office.

Investigator Peterson and Investigator Zuccarelli selected 20 charts at random from respondent's file cabinets and reviewed them. Of the 20, they had concerns about seven. They wrote detailed notes and copied information verbatim from the records. They replaced all of the charts along with about 50 others on top of the cabinets. Later, Investigator Zuccarelli reviewed the final information by checking it against the notes which Investigator Peterson was putting into her report. The two investigators believed that the S.C. and B.A. charts reflected second trimester procedures having been performed. Sonograms were not identified, and there were no records of postoperative monitoring.

Investigator Peterson returned to the Voorhees office with the second impound order (Exhibit P-63) on September 29, 1993. With her were Investigator Zuccarelli and Investigator Ben Ricciardi, as well as Lt. Hummel. Her purpose was to obtain the original seven records that were reviewed on the 15th of September. She gave Elizabeth Navarra a copy of the order and began to look for the records in the same cabinet as before. She could only find L.R.'s chart. Respondent did not know to which other office the other charts had been moved. Eventually, Dr. Brigham located S.C.'s chart within the cabinet and gave it to the investigators. The investigators later drove up to Spring Valley where respondent's staff had moved many charts, and a staff member provided the originals of four other charts. The M.A. chart was later found back in the Voorhees office. The charts at issue are Exhibits P-6, P-7, P-10, P-11, P-12, and P-13.

Investigator Peterson believed there were two material alterations found when she compared these charts with her notes from the 15th of September. She believed S.C.'s chart originally had a sonogram reflecting 22-23 weeks; this sonogram had vanished from the chart by the time the investigators returned to impound it 14 days later. She believed B.A.'s chart originally had a fully completed abortion procedure record signed by respondent as part of the chart when it was inspected on September 15, 1993; by September 29, all that was left of this part of the chart was a page-long description of the procedure of insertion of laminaria in the patient (Exhibit P-21). Five charts which showed completed abortions had no recovery room records.

Dr. Kotopolous testified that it is the generally accepted standard of care in New Jersey to identify sonogram prints with the patient's name and the date. In his opinion, the absence of the patient's name and the date on the sonogram prints for patients M.B. and J.K. (Exhibits P-22A and P-1A) is a deviation from the generally accepted standard of care. It was Dr. Hollander's opinion that sonograms should be identified with a patient identification number or a patient name. Dr. Kotopolous also testified that it is the generally accepted standard of care to monitor vital signs during and after an abortion procedure. This is done so that if there is any abnormality, intervention measures can be taken. It was also his opinion that it is the generally accepted standard of care to record the findings, for future reference medically and legally.

E.C. is a diagnostic medical sonographer. She testified that usually the name of the patient should be shown on the sonogram print. However, sometimes it is forgotten. She did not see this to be a problem if there is a report. Dr. Burnhill testified that some of the older machines did not have the capacity to print the name of the patient. Since the sonogram when viewed real time has so much more information than can be represented in a mylar printout, it is not the standard of care to keep the mylar printouts in the record of examination. Rather, the written report is kept, and only the report and live pictures can be relied upon in patient care and diagnosis. This is illustrated by the hospital report for J.K., where no mylar printout was kept, and all that is contained in the record is the sonogram report.

Dr. Brigham testified that no ultrasound imaging was done for patient S.C., and therefore, no ultrasound report was done. He said that if the State's investigators saw a sonogram printout or report in S.C.'s chart, it did not belong there. He also noted that there would never be a mylar print without a report, although there might be a report without a mylar print. After S.C.'s procedure on August 12, 1992, Dr. Brigham had no dealing with S.C.'s chart until it was handed to the investigators during the second of their two visits in September 1993. He sincerely testified that he neither put anything in the chart nor took anything out during that time, nor did he ask or approve of anyone else doing that.

In regard to patient B.A., Brigham emphatically and sincerely denied terminating her pregnancy and evacuating her uterus in the Voorhees office. Rather, the abortion procedure was performed in New York, at the All Women's Medical Pavilion. Brigham believed that B.A. was the last patient who had her laminaria inserted in New Jersey, and he said that there was no dishonesty or deception in the records; they reflect what happened with the patient. The Voorhees record reflected what occurred there. The record forms and notations are those commonly used in this area of practice and they are consistent with good and accepted standards of medical care and record keeping. The rest of the abortion procedure record was completed in New York. Brigham absolutely denied any alteration of B.A.'s records between visits by the State's investigators and he insisted that the laminaria insertion notes were in the chart on September 15, 1993. It was also his opinion that even if there were any deviation in record keeping in these cases, it had no effect on the care that the patients received, and therefore there was no negligence.

Kathleen Parisi is a licensed practical nurse who has cared for many ill patients in her career and who has attended numerous seminars and conferences on medical care. She started working at the American Women's Center in Voorhees in June 1992 and is now the office manager. Ms. Parisi identified her handwriting on the recovery room records for patients L.R., C.E., M.B., and S.C. (Exhibits R-2, R-42, R-43, and R-44). It was Ms. Parisi's sincere and credible testimony that she created the documents on the dates shown to record the patients' vital signs on those dates, and she signed them. She testified that she followed the same procedure of monitoring and recording vital signs for all patients in the recovery room.

Ms. Parisi testified that she was present at the office on September 15, 1993, when the investigators came. They made no request of her and they refused the offer of a room. Instead, they stayed in the main hallway looking at charts, and there was a lot of commotion. Ms. Parisi testified that when the investigators came to the office, the recovery room records were in a cabinet right near the table where they were looking at patient charts. The cabinet had initially been in the recovery room, but was moved next to the table some months earlier. Ms. Parisi was a sincere and credible witness.

B.G. is a registered medical assistant and blood lab work technician. She was hired at the Voorhees office in September 1992. It was her credible testimony that patients were monitored in the recovery room and the vital signs were recorded. It was B.G.'s task to photocopy the blank recovery room forms every week, as a new form was needed for each patient. Originally, the filled out and signed recovery room records were kept in a file in the recovery room. Later, the file cabinet was moved out of the recovery room. B.G. testified that she was present when the

investigators came to the office. She felt they were arrogant and rude, and noted that they did not ask for any specific records. The recovery room records were at that time in a filing cabinet right next to the desk which the investigators were using. B.G. was a credible witness.

DISCUSSION

Complainant asserts that the evidence is clear that on September 29, 1993, the investigators served respondent or his staff with a court order for production of complete medical records on certain patients (Exhibit P-63) and that respondent and several staff members were aware of the contents of the Order and were consulting with counsel about it. The evidence is also clear that five of the charts retrieved on September 29, 1993, including four produced from their place of storage in Rockland County, did not have recovery room records (Exhibits P-6, P-10, P-11, P-12 and P-13). Three months later, in response to the charges filed by the Attorney General, respondent's office suddenly produced copies of the purported original recovery room records which were maintained on these five patients. As admitted by Kathy Parisi, that was the first time these records were produced (Exhibits R-2, R-23, R-42, R-43 and R-44) despite the mandate of the court order. The complainant suggests that these five recovery room records be place side-by-side and examined as to whether they bear the indicia of contemporaneous records. In particular, complainant notes the constancy of the handwriting and striking similarity of the actual entries.

Respondent asserts that he has committed no act of negligence in regard to these allegations. The evidence as to the records of S.C. and B.A. which the complainant presented was dependent on the memories of the investigators. There is no credible evidence in the record to establish that there actually was an alteration of records, or that any such alteration was intentionally done, or that it was done by respondent. Since S.C.'s own affidavit establishes that she did not have a sonogram, and B.A.'s abortion was clearly not performed in New Jersey, there was never any wrongdoing by respondent and no reason to alter records existed.

Respondent also asserts that he has shown that it is not the standard of care to even print a mylar printout of a sonogram, as it is not used in the diagnosis of the patient. The lack of a patient identifier on a mylar printout has not been shown to have any impact on the quality of care provided, and complainant thus can not establish any negligence. Respondent also asserts that because of the gestational age of D.V.'s fetus, she was not accepted as his patient. Therefore, a sonogram report was not necessary for patient care.

I agree with the respondent. I FIND that the respondent did not intentionally or negligently alter his medical chart for S.C. by removing a portion of the chart, or maintain an inaccurate record by placing someone else's sonogram into S.C.'s chart. I FIND with regard to patient B.A. that the respondent did not intentionally or negligently alter his medical chart for the patient.

Based upon the foregoing, I further FIND that respondent Brigham was not negligent and did not engage in conduct which violates N.J.A.C. 13:35-4.2 and - 6.5. Thus, I CONCLUDE that respondent's conduct did not constitutes grounds for the revocation or suspension of his license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d) and(h).

I FIND that some of the sonograms in respondent's charts for dates prior to October 1993 were not identified with the patient's name or the date. However, I further FIND that this was not a departure from generally accepted standards of care and that it in no way interfered with the quality of care provided. I further FIND that this conduct does not constitute repeated acts of negligence or professional misconduct. Thus, I CONCLUDE that respondent's conduct did not constitute grounds for the revocation or suspension of his license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d), (e), and (h).

Based upon the credible evidence in the record, I FIND that respondent properly

monitored intraoperative and postoperative vital signs. I FIND that it was not within the generally accepted standards of care to record intraoperative vital signs for first trimester abortions lasting under five minutes. I FIND that respondent's staff properly monitored and recorded patient's postoperative vital signs in the recovery room.

Base upon the foregoing, I further FIND that respondent's conduct did not constitute professional misconduct, nor repeated acts of negligence. Thus, I CONCLUDE that respondent's conduct did not violate N.J.A.C. 13:35-6.5, and did not constitute grounds for revocation or suspension of his license to practice medicine in this State, pursuant to N.J.S.A. 45:1-21(d) and (h).

The issue of whether respondent violated the termination of pregnancy regulation, N.J.A.C. 13:35-4.2, by inserting laminaria in patients who were beyond the 14th week LMP will be addressed below.

Alleged Failure to Ascertain Length of Pregnancy Within Generally Accepted Margin of Error (Amended Complaint, Count IV (S.C.)) and Second Complaint, Count II (D.V.)

Complainant's allegations at Count IV of the Amended Complaint concerning patient S.C. are described above. At the completion of the complainant's case in chief, some of the allegations of Count II of the Second Complaint were dismissed for failure to establish a prima facie case. The complainant's remaining allegations in this count of the Second Complaint are that on August 19, 1993, respondent was unable to determine the gestational age of patient D.V.'s pregnancy with any specificity, and that he advised D.V. that the gestational age was between 16 and 30 weeks. Complainant alleges that D.V. was between 32 and 35 weeks pregnant when respondent examined her, and that his inability to determine her gestational age within any range of medical certainty constitutes gross incompetence. Thus, complainant alleges that respondent's conduct constitutes grounds pursuant to N.J.S.A. 45:1-21(c) for the revocation or suspension of his license to practice medicine or surgery in this State.

The findings of fact which follow are derived from the credible evidence in the record. D.V. was a 20 year old patient who went to respondent's office on August 19, 1993. She has claimed that Dr. Brigham gave her varying estimates of her weeks of gestation, from 16 to 30, and then said he did not know. D.V. has acknowledged that Dr. Brigham advised her in front of his assistant that she was 32 weeks pregnant, but has also claimed that he called her aside into his office and insinuated that he might be able to do something for her if she would go to his Rockland County office. D.V. then went to Metropolitan Medical Associate where Dr. Kotopoulos took a sonogram and told her that she was late in her third trimester, about 35 weeks or 88 mm. BPD (Exhibit P-25).

Respondent's chart (Exhibit P-24) contained 8 undated, unidentified sonograms of D.V. and no written sonogram report. He was using a 7.5 mgh transvaginal probe because his 3.5 mgh transabdominal probe was broken. The 7.5 mgh transvaginal probe is not the right piece of equipment to use when one needs to obtain an accurate sonogram in the third trimester. Instead, a 3.5 mgh transabdominal probe is the correct equipment. Use of a 7.5 mgh transabdominal ultrasound results in not being able to obtain a complete BPD because the 7.5 produces lesser penetration and a narrower field of view.

S.C.'s chart (P-6) reflects the following: LMP of 9 weeks, pelvic exam findings of 11 weeks, tissue examination finding of 15-16 weeks. Complainant also asserted that there was an unidentified sonogram originally seen by investigators Peterson and Zuccarelli in S.C.'s chart reflecting 20-22 weeks gestation. If the sonogram did pertain to S.C., it clearly did not correspond to the other findings for it was well beyond the acceptable margin of error for a second trimester pregnancy in second trimester. The 15 to 16 weeks conclusions are also well beyond the margin of error if the patient's report of 9 weeks LMP was correct. Dr. Brigham testified that his pelvic examination of S.C. gave him a gestational age estimate of 11

weeks, and he believes about 13 and one-half weeks was the true gestational age. Thus, he feels his estimate was within the accepted margin of error and within the generally accepted standard of care.

Narda Johnson is a diagnostic ultrasound technician. She has worked in that field since 1983, and has been a certified sonographer since 1984. An employee of Greenwich Ultrasound, with duties at Greenwich Hospital in Connecticut, Johnson specializes in obstetrical sonography. She normally uses three measurements for determining gestational age of a fetus. She specializes in high risk fetuses, and testified that it can take up to 30 minutes to do an obstetrical scan. Ms. Johnson estimated that she has done close to 80 thousand ultrasounds.

Ms. Johnson examined sonograms from Exhibits P-24 and P-25, concerning patient D.V., and acknowledged that a biparietal measurement could not be done with the 7.5 transvaginal probe. She said that she could see the femur bone in the first two sonograms (Exhibit P-24), and she opined that the sonograms were appropriately taken and measured. Ms. Johnson noted that inexperienced people sometimes measure "artifacts" or "noise" shown in the picture. In these sonograms, the artifact was not included in the caliper placement, indicating that respondent knew what he was doing. Since he was using a 7.5 mgh transducer, she felt he was doing a very good job, and she considered the gestational age estimate for the second picture to be accurate. On the other hand, the picture of the fetal skull in the third picture was taken at an oblique angle, and it would not provide a correct gestational age, because one can not use a 7.5 probe for the biparietal measurement, and because the correct anatomical plane has not been used.

According to Ms. Johnson, the fifth picture appeared to be the correct anatomical plane. She identified brain tissue, and said that for an accurate measurement of the fetal head, the fetal brain is a landmark to look for. In her opinion, the picture did not show the bladder. She felt picture five indicated how one would try to use a 7.5 probe for a biparietal measurement if forced to do so. In other words, it shows the operator knew what he was doing, trying to use the equipment as best he could. He could approximately identify anatomical structures, and he knew what measurements to try to take to have sufficient information to estimate gestational age. She acknowledged that if respondent told the patient that she was at 15 or 16 weeks, or at 25 or 26 weeks, that information would not have been correct. However, in her opinion, Brigham correctly used the femur length for his gestational age estimate of 32 weeks. It was enough information to tell the patient she was too far along to have an abortion. Ms. Johnson was a sincere, candid and credible witness.

Kathleen Parisi recalled patient D.V., as she had missed two appointments before coming to the office. Noting that no patients are alone with the doctor, Ms. Parisi stated that she was present the entire time D.V. was with Dr. Brigham on August 19, 1993. He did a pelvic examination and told her that she was further along than she thought. D.V. made it clear that she wanted to have an abortion. Dr. Brigham gave her an ultrasound, but he tried to do it using the vaginal probe, because the abdominal probe had been sent out to be fixed. According to Ms. Parisi, Dr. Brigham kept looking at the screen as he moved the probe, and he took numerous pictures. After a considerable time, he told her that she was 32 weeks pregnant and that he could not do the abortion. D.V. was hysterical at this news and said she would do anything to have an abortion. Dr. Brigham told her it was not a financial issue; it was a legal matter. D.V. gave birth about four weeks later, and the hospital estimated her gestational age to be 35 to 36 weeks.

In regard to patient S.C., Dr. Brigham testified that she had indicated her LMP to be June 13, 1992, which would mean about nine weeks gestation. When he did his pelvic examination of S.C., Dr. Brigham estimated the pregnancy to be at eleven weeks, which he described as within the accepted range of error. It was not a large discrepancy from the patient's information. The respondent testified that no sonogram was necessary, and it was not his practice to do a sonogram under the circumstances. It is his opinion that it is not within the generally accepted standard of care to do an ultrasound for first trimester abortions, when the pelvic examination and the patient's estimate are consistent, and both are within the first trimester. He said that his opinion comports with the standards of the

National Abortion Federation. Dr. Brigham testified that neither the Harrisburg nor Flushing centers do sonograms for first trimester abortions, and he is aware of at least two licensed New Jersey facilities where this is also true.

Dr. Brigham explained that he was trained to do pelvic examinations by observation, and then he was observed and supervised as he did them. He has similarly trained others, and he estimated that he has done between twenty thousand and thirty thousand pelvic exams. Dr. Brigham described the method he followed for a pelvic examination. He first examines the external genitalia for normalcy, then inserts one and then two lubricated fingers into the vagina. He places his left hand on the fundus of the uterus and pushes. By doing this, he is seeking a clear understanding of the angle of the cervix and cervical canal, and the size of the uterus. There is an approximate correlation between the size of the uterus and gestational age, with a margin of error of about three weeks.

Dr. Brigham testified that some patients are more difficult to assess for gestational age because of factors such as obesity, retroverted uterus, tensed abdomen, infection or pelvic tenderness making the exam painful. According to Dr. Brigham, he has had a number of ways to assess the accuracy of his pelvic exams. At Columbia Medical School, he had the feedback of professors who examined the same patients he did. Planned Parenthood did not do ultrasounds, so a good pelvic exam was important, and Dr. Brigham testified that they felt his estimates were on target. However, the most accurate feedback he has received has been from doing thousands of pelvic exams following sonography, and the estimates of gestational age have correlated very closely. Dr. Brigham feels he will be within a week or two of the sonographer's estimate.

Dr. Brigham noted that there has been no other allegation raised concerning the adequacy of his pelvic exams besides that concerning S.C., and she had refuted the Complainant's allegations in her affidavit (Exhibit R-14). She did not receive an ultrasound, and to the best of her knowledge, she was in her first trimester of pregnancy at the time of the abortion. Dr. Brigham also noted that the fetal tissue examiner had recorded 14 millimeters as the fetal foot length (Exhibit P-6). Dr. Brigham testified sincerely that he did not know who wrote on S.C.'s chart an estimated gestational age of 15 to 16 weeks, followed by two question marks, but he interpreted the entry to mean that the tissue examiner on his relatively inexperienced staff was doubly unsure of the estimate. According to Dr. Brigham, the examiner strains the products of conception and then lays out the fetal part for measurement with a ruler. A fetal foot length of 14 millimeters, as was measured by the tissue examiner, corresponds to a gestational age of 13 and one-third weeks LMP according to the tables of the National Abortion Federation (Exhibit R-55). Even assuming the full margin of error of two millimeters, a fetal foot length of 16 millimeters would correspond to only 14 weeks LMP (Exhibit R-55), and would be within the legal limit for the procedure.

In regard to patient D.V., Dr. Brigham testified that she had come to his office seeking an abortion and not to get an estimate of her gestational age. He noted that she went to Dr. Kotopolous' facility in Englewood after leaving his office. According to Dr. Brigham, by her reported LMP, she would have been late in her second trimester. He did an external exam of her abdomen and a pelvic exam and estimated the gestational age to be 32 weeks from LMP. D.V. was emphatic about wanting an abortion, and he tried to break it to her gently that she was too far along in her pregnancy. In accord with the testimony of Ms. Parisi, Dr. Brigham testified that he did the best he could to obtain a satisfactory sonogram measurement using the transvaginal probe. Eventually he obtained an accurate measurement of femur length, yielding an estimated gestational age of 32 weeks. He told D.V. this news and that he could not do an abortion. He suggested that she plan for prenatal care. Dr. Brigham's testimony was thorough, sincere, and entirely worthy of belief.

DISCUSSION

Complainant argues that the sonograms respondent took of D.V. reflect that

respondent lacks knowledge in taking accurate sonogram measurements and in dating a pregnancy. In #1 and #2, the femur lengths are not accurately measured and in #3 the biparietal diameter (BPD) does not reflect necessary landmarks; in #5, a 33 mm. BPD measurement is of the bladder, not the fetal head; in #6 there is no structure which can design the head even though it is denominated a biparietal diameter (BPD); #7 is a BPD but again does not clearly measure the head; and #8 is partly the head and partly the bladder even though it is denominated BPD. The generally accepted margin of error for a patient who is 32 weeks pregnant is plus or minus 17 to 21 days. Six of D.V's eight sonograms were therefore outside the acceptable margin of error.

Complainant contends that for S.C., the pelvic exam findings reasonably correlated to the 9 week LMP, but was 5 to 6 weeks inaccurate when compared to the actual gestational age assessed at the end (15-16 weeks). The discrepancy in these findings demonstrates that respondent failed to accurately assess the gestational age of S.C.'s pregnancy and that he was negligent.

Respondent contends that he accurately estimated D.V.'s gestational age, even though he was handicapped by broken equipment. Not only was his estimate within any reasonable range of medical certainty, it was correct. Complainant concedes that respondent told D.V. she was at 32 weeks gestation. Respondent also asserts that he was within an acceptable range of error in estimating the S.C.'s gestational age. The measured fetal foot length of 14 millimeters corresponds to 13 weeks and three days, so his estimation of gestational age by examination was only off by two weeks.

I agree with the respondent. I FIND that respondent did not fail to accurately assess the status of S.C.'s pregnancy and that he was able to determine the gestational age of patient D.V.'s pregnancy with specificity. I further FIND that respondent Brigham's conduct concerning patients S.C. and D.V. did not constitute negligence nor gross incompetence. Thus, I CONCLUDE that respondent's conduct did not constitute grounds pursuant to N.J.S.A. 45:1-21(c) for the revocation or suspension of his license to practice medicine or surgery in this State.

Alleged Commencement or Performance of Abortions at a Point Beyond the 14th Week LMP in Violation of State Regulations

J.K. (Amended Complaint, Count I)

Case in May 1993 (Amended Complaint, Count II)

S.C. (Amended Complaint, Count IV)

B.A. (Amended Complaint, Count V)

The allegations and facts concerning patients J.K., S.C., and B.A. are described above and need not be repeated here. As to Count II of the Amended Complaint, the complainant alleged that respondent performed an abortion at the Voorhees office around May 1993 on a patient who was at 23 weeks gestation. The source of this allegation was Ellen Stott, who is a registered nurse practitioner in obstetrics and gynecology and who has been a practicing nursing for ten years. As a result of her specialized registration as a nurse practitioner, she can have her own patients and provide a certain specified range of care for them. She was employed by respondent from April 1993 to October 1993, when she quit.

Ms. Stott claimed that about two or three weeks after she started working for respondent, she was informed by Kathy Parisi and B.G. that a 24 to 26 week procedure had been performed in the office, and that staff member B.G. had been the only staff member on the premises at the time and had become very upset about it. Ms. Stott further claimed that Ms. Parisi had found the products of conception in a medical waste bag. When she confronted Dr. Brigham about this, she says he did not deny that this event had taken place; rather, he justified the abortion by saying that it was a fetal demise and was a 23 week procedure, not 26 weeks. She said that

it was an explanation that she could deal with.

Respondent, Ms. Parisi, and B.G. each denied that the abortion described by Ms. Stott had taken place. There testimony was candid and sincere, and entirely worthy of credit. It is more likely than not that Ms. Stott, who herself saw none of what she described, was confused by discussion at the office concerning the case of J.K., and that Ms. Stott must have been mistaken. I so FIND. Thus, I CONCLUDE that Count II of the Amended Complaint must be dismissed.

DISCUSSION

N.J.A.C. 13:35-4.2 sets forth the regulations regarding termination of pregnancy. The rule clearly contemplates that beyond 14 weeks LMP, the uterus cannot be evacuated except in specified facilities by physicians with specified credentials. There is no distinction stated in the rule for cases in which the fetus had demised before the abortion. The rule is silent on insertion of laminaria.

Complainant contends that the insertion of laminaria in a patient who intends to have an abortion, when the laminaria are inserted for the purpose of dilating the cervix preparatory to removal of the fetus and placenta, is the commencement of that abortion procedure. Although some patients may have the laminaria removed and go on to successfully deliver a baby, the basic premise is still that insertion of laminaria commits the patient to termination of the pregnancy.

Complainant further contends that the insertion of the laminaria was the initial medical procedure towards J.K.'s abortion, since Dr. Brigham was utilizing a passive dilation technique. There was no other purpose for the laminaria insertion in J.K. To the extent that laminaria might be removable from a patient and the process of dilation and abortion interrupted, respondent no doubt knew that he would not be removing the laminaria and thus stopping this process in J.K., who had a fetal demise.

Dr. Jeffrey Moskowitz testified on behalf of respondent that, in his opinion, insertion of laminaria does not constitute performance of an abortion. Laminaria are intended to dilate the cervix, while he defines an abortion as evacuation of the uterus. These procedures have separate billing codes. Dr. Moskowitz said that in New York, nurse practitioners are allowed to insert laminaria, but they are not allowed to perform abortions. He also noted that patients are vigorously counseled (that insertion of laminaria is intended to dilate the cervix so the abortion can be performed), but some patients change their minds and have the laminaria removed. The vast majority of these patients go on to deliver a baby at the end of their pregnancy. Unlike the laminaria, the evacuation of the uterus can not be reversed. The essence of Dr. Moskowitz's opinion in this regard was that insertion of laminaria does not evacuate the uterus, so it is not commencement of an abortion. He acknowledged that insertion of laminaria is a step in the process, in the same way that the decision to have an abortion is a step.

Dr. M.A.B. testified that insertion of laminaria does not and could not equal an abortion. The insertion of laminaria involves only the cervix. It is simply a means of softening and dilating the cervix, and it does not cause an abortion. The patient can change her mind, the laminaria can be removed, and the patient can carry to term and deliver.

It was the opinion of respondent Brigham that insertion of laminaria does not constitute performance of an abortion. He offered several reasons. First, insertion of laminaria does not terminate the pregnancy; it neither kills nor evacuates the fetus. It is possible to remove the laminaria and have the patient go on to deliver a healthy baby. Second, their are separate codes for insurance coverage for insertion of laminaria and for abortions, and laminaria may be inserted for dilatation purposes unrelated to abortions. Finally, in some contexts it is permissible for non-physicians to insert laminaria, but only licensed physicians may perform abortions. So, Dr. Brigham testified, he had every reason to believe that in New Jersey insertion of laminaria would not be deemed performance of an

abortion. He felt that he was in compliance with the spirit and the letter of the time limit regulation, and with the standard of practice in this state. Nevertheless, he stopped inserting laminaria in New Jersey around December 1992, based upon his understanding that the Board felt he should not.

Putting aside the question of laminaria insertion, Dr. Brigham categorically denied ever intentionally performing an abortion in New Jersey beyond the 14 weeks limitation. As noted above, Dr. Brigham testified that his pelvic examination of S.C. gave him a gestational age estimate of 11 weeks, and he believes about 13 and one-half weeks was the true gestational age. Thus, he feels his estimate was within the accepted margin of error and within the generally accepted standard of care. He likewise categorically denied the allegation of evacuating a fetal demise at 23 weeks in his New Jersey office. Dr. Brigham testified that there has never been a fetus of any gestational age placed in his trash. Also as noted above, in regard to patient B.A., Dr. Brigham emphatically and sincerely denied terminating her pregnancy and evacuating her uterus in the Voorhees office. Rather, the abortion procedure was performed in New York, at the All Women's Medical Pavilion.

It is clear that insertion of laminaria does not terminate a pregnancy. It is likewise clear that it is a necessary step in achieving adequate cervical dilatation so that evacuation of the uterus can be accomplished safely. The Board is of course free to interpret the scope of its rule on termination of pregnancy, in accordance with reason, fairness, and adequate notice to those who are regulated. It would be well if the rule specifically addressed the use of laminaria, as I am convinced that Dr. Brigham would not have utilized the procedure in New Jersey for patients beyond the 14th week of pregnancy if the rule expressly defined laminaria insertion as a termination procedure. Dr. Brigham voluntarily stopped inserting laminaria in New Jersey about a year before the Board issued its interim order barring him from such procedures, when he learned of the Board's apparent interpretation.

Based upon the foregoing, I FIND that respondent did not intentionally nor negligently violate N.J.A.C. 13:35-4.2. Thus, I CONCLUDE that respondent's conduct does not constitute grounds for the revocation or suspension of his license to practice medicine and surgery in this State.

Alleged Misleading Advertising (Amended Complaint, Count X; Second Complaint, Count III)

Complainant alleges at Count X of the Amended Complaint that respondent's published advertising in New Jersey in 1992 and 1993 for his New Jersey and New York offices of safe, gentle, and painless abortions to 24 weeks was deceptive and misleading. Complainant alleges that this violates N.J.A.C. 13:35-6.10 and constitutes grounds for the revocation or suspension of Respondent's license to practice medicine in this State pursuant to N.J.S.A. 45:1-21(h).

Complainant alleges at Count III of the Second Complaint that respondent's telephone yellow pages advertising as of March or April 1994 of safe, gentle abortions constituted the employment of deception, misrepresentation, false promise or false pretense, in violation of N.J.S.A. 45:1-21(b).

Tom Kearney testified that he is a sales representative for New Jersey Yellow Pages advertising, and he handled the accounts for American Women's Center. He dealt with respondent beginning in June 1992, and they met to discuss the Center's account which was billed to a Voorhees phone number. Kearney also met with Kathy Parisi and Liz Navarra who acted on respondent's behalf. In 1992 and 1993, respondent had ads running in almost all of the 38 New Jersey Yellow Pages Directories. It is unrefuted that Dr. Brigham has directed that changes be made in his advertisements when he learned that the Board had concerns about their content. It is also unrefuted that Dr. Brigham believed his advertisements, which offered safe, gentle, painless abortions, and later offered safe, gentle abortions, to be truthful.

DISCUSSION

Complainant contends that respondent's advertisements are deceptive and misleading. Some of the respondent's ads offer "safe, gentle, painless" abortions (Exhibits P-14, P-16, P-51, and P-52). On the other hand, the fact sheet provided to patients as part of the informed consent paperwork (see, Exhibit P-22, pages 18 and 19) describes possible complications that would no doubt cause pain, including perforations, lacerations, and suturing. In addition, it is undisputed that insertion of laminaria in second trimester terminations can cause significant cramping. Complainant asserts that these factors are inconsistent with representations of "safe" and "painless."

Respondent asserts that the advertising is true. No patient complained of pain or of being misled. The fact that there is a slight chance of a complication, or that there might be cramps after the procedure, does not render it unsafe or painful. Respondent had a reasonable basis for the clarity and accuracy of the advertisements and he had no intent to mislead or deceive. In addition, respondent asserts that he has acted in good faith in changing his advertisements He points to his undisputed efforts to receive guidance from the Board, which notified him on three different occasions over the course of two years of three different problems it had with the same advertisement. He has attempted to comply with the Board's wishes.

N.J.A.C. 13:35-6.10 regulates advertising and solicitation practices. The relevant part appears to be

(c) A Board licensee who engages in the use of advertising which contains any of the following shall be deemed to be engaged in professional misconduct:

1. Any statement, claim or format including, but not limited to, a graphic representation, which is false, fraudulent, misleading or deceptive.

(N.J.A.C. 13:35-6.10(c)1.)

N.J.S.A. 45:1-21(b) prohibits the use of dishonesty, fraud, deception, misrepresentation, false promise or false pretense. The Appellate Division construed and applied N.J.S.A. 45:1-21(b), as well as N.J.S.A. 45:12-11(h) and (o), in In re Shack, 177 N.J. Super. 358 (App. Div. 1981). The latter two sections prohibited false, fraudulent or misleading advertising of the practice of optometry and any conduct which is of a character likely to deceive or defraud the public. The case involved alleged violations of the foregoing statutes by two optometrists who placed a newspaper ad regarding soft contact lenses.

The court determined that valid analogies may be drawn from those cases construing the "deception" portions of the New Jersey Consumer Fraud Act and the Federal Trade Commission Act. Id. at 363. The court quoted the Consumer Fraud Act's definition of an unlawful practice as the "use or employment of any ... deception (or) misrepresentation ... in connection with the sale or advertisement of any merchandise or real estate ..., whether or not any person has in fact been misled, deceived or damaged thereby" ... Ibid. The criterion by which the advertising was judged was "the likelihood of deception or the capacity to deceive." Ibid. A prime element of deception was determined to be the capacity to mislead. Ibid.

I agree with the complainant's contentions. Without suggesting that a physician need list possible complications or side effects in his or her advertisements, the unstated possibility of those events occurring means that the unqualified declaration of the availability of "safe" and "painless" abortions had the capacity to mislead a prospective patient. I FIND that the advertisements of respondent which are the subject of these charges had the capacity to mislead. However, it is apparent that the respondent believes his advertisements have been truthful, and I FIND that he had no intent to deceive or mislead. Nevertheless, I CONCLUDE that this conduct violates N.J.A.C. 13:35- 6.10(c)1, and that the respondent is therefore deemed to have engaged in professional misconduct. I further CONCLUDE that this conduct violates N.J.S.A. 45:1-21(b) because the advertisements had the capacity to mislead.

The respondent's lack of intent to deceive is significant. Equally significant are his earnest efforts to comply with the Board's wishes concerning advertising. While his violations of the foregoing regulation and statute constitute grounds for revocation or suspension of his license to practice medicine and surgery in New Jersey pursuant to N.J.S.A. 45:1-21(b), (e), and (h), his lack of intent and his good faith efforts to comply compel a less harsh result. I CONCLUDE that the appropriate resolution of these violations is prospective; the respondent shall not place any advertisements which mislead or have the capacity to mislead, as determined by prior approval from the Board.

Alleged Failure to Comply with the Board's Monitoring Order in a Timely Manner.

Complainant has charged Dr. Brigham with failure to timely comply with the Interim Order of the State Board of Medical Examiners, announced orally on December 23, 1993, and issued in writing on February 7, 1994, which in part required him to secure the services of a supervisor acceptable to the Board who would review his records and file monthly reports. Complainant asserts that the alleged failure to timely comply constitutes professional misconduct and is therefore violative of N.J.S.A. 45:1-21(e).

The oral order set forth no time frame for compliance. It was the unrefuted and credible testimony of Dr. Brigham that he asked Deputy Attorney General Nancy Costello-Miller, counsel for the Board on December 22, 1993, what he needed to do about the monitoring and was told that the Board would be getting in touch with him. Dr. Brigham then heard nothing on the subject for about two months, and not knowing what kind of person the Board would consider for a monitor, he admittedly did not contact anyone about assuming that task during that time. During the last week of February 1994, Dr. Brigham met with his counsel to discuss compliance with the Board's written Order. Since the Order did not describe the necessary monitor credentials, Dr. Brigham surmised that the Board's concern was verification that he was not performing second trimester abortions. Thus, he felt someone from his office would be appropriate, but he also compiled a list of possible monitors which included a variety of outside professionals.

Dr. Brigham knew that he would be unable to meet and reach agreement with the people on his list in the eight business days remaining before the next meeting of the Board, so his self-imposed deadline for submitting the list was April 13, 1994, the date of the following Board meeting. Most of the many people Dr. Brigham approached to become his monitor refused, for a variety of reasons. Meanwhile, no one from the Board contacted him before he submitted his first list of seven proposed monitors on April 8, 1994 (Exhibit P-34). Dr. Brigham asked that the Board give him guidance if the list, which included Dr. A.K., was not acceptable. The Board met on April 13, 1994, and it requested a copy of Dr. A.K.'s curriculum vitae. By letter dated April 21, 1994 (Exhibit P-54), counsel for complainant sent counsel for Dr. Brigham the monitoring agreement to be immediately signed and delivered upon the Board advising that Dr. A.K. was acceptable. On April 25, 1994, counsel for Dr. Brigham faxed Dr. A.K.'s curriculum vitae to counsel for the Board.

On May 2, 1994, counsel for complainant sent counsel for Dr. Brigham two revised copies of the monitor agreement (Exhibit P-56), with instruction that they be signed and mailed to the Board's Executive Director immediately. Counsel for complainant also stated that Dr. A.K. should be instructed to start the monitoring process. By letter dated May 10, 1994 (Exhibit P-57), Dr. Brigham submitted the monitor's agreement that he and Dr. A.K. had signed. Dr. Brigham testified that he then waited to see if the agreement would be ratified by the Board, or disapproved, but he heard nothing. Notwithstanding that he did not hear back from the Board, Dr. Brigham asked Dr. A.K. to begin monitoring. Dr. A.K. had two problems which prevented him from beginning immediately. One was his concern about liability, and the other was his wife's illness. Dr. K. was able to and did begin monitoring in June 1994, and issued his first monitoring report on July 15, 1994.

Dr. A.K. testified that he agreed to be respondent's monitor without reservation, and his immediate concern was whether the respondent could sue him if he came out

with a harsh criticism. He was also concerned about potential liability if the respondent mishandled a patient. According to Dr. A.K., he tried to discuss these issues with the Attorney General's office, but had trouble getting through to the person to whom he needed to talk. It took about five weeks to have the matter worked out in writing, and then he spent about four weeks taking care of his wife after she had serious surgery. As soon as he was able, he commenced monitoring. It was the testimony of Dr. A.K. that he undertook to check respondent's records and monitor his practice as the eyes and ears of the Board.

According to Dr. A.K., Dr. Brigham was very cooperative and provided complete access, and instructed his staff to do the same. Dr. A.K. found respondent's equipment to be far above average; his sonography equipment was state of the art and he had a trained sonographer. Dr. K. stated in his monitoring report (Exhibit P-36):

In my review of the above documents (patient medical records), I found no violations of the Board's order. To the contrary, at every point Dr. Brigham evidenced good faith in complying with the order. Also, during my review of the records, I found no evidence of any violations of New Jersey Law, and no substantial deviations from generally accepted medical standards . . . .

I would like to point out that my monitoring of Dr. Brigham has gone far beyond the mere "chart review" mandated by the Board in the agreement I signed. With the full and complete cooperation of both Dr. Brigham and his staff, I have conducted a complete inspection of both offices, interviewed and questioned the staffs of both offices, reviewed the practice protocols and procedures currently in existence, checked the medical equipment and emergency supplies, reviewed the back-up arrangements, held extensive discussions with Dr. Brigham and other physicians working with him, and I have even personally observed Dr. Brigham as he performed an abortion on a patient. All of this was done with the cooperation and even encouragement of Dr. Brigham.

Based upon all of this information, as well as the chart reviews, I would like to inform the Board that I believe Dr. Brigham's total practice is within generally accepted standards of care. I also believe that he does not pose a danger to the people of the State of New Jersey. . . .

In conclusion, I view my role as the "eyes and ears of the Board." In that capacity, I feel the Board needs to have very little concern over Dr. Brigham. Of course, it is inevitable that complications will occur as with any physician, but this physician's complication rates are very low, and he is currently practicing above the standard of care. Even more important, is that his attitude is one of a willingness to cooperate, to obey the Board's orders, and to improve in any way possible as a physician and as a provider.

DISCUSSION

Complainant contends that there was an inordinate delay on respondent's part in securing a monitor. No effort was made to secure a monitor in response to the Board's oral order of December 22, 1993, and complainant asserts that respondent should have begun efforts to find a supervisor in anticipation of the anticipated written order. Even though the written order was filed on February 7, 1994, the monitor's first report was not issued until July 15, 1994. Complainant contends that this delay constitutes professional misconduct, in violation of N.J.S.A. 45:1-21(e).

Respondent first contends that he was advised of no time frame for securing a monitor, and when he specifically inquired of Deputy Attorney General Nancy Costello-Miller, who was then representing the Board, he was told the Board would be getting in touch with him. Second, respondent contends that after he submitted the monitor agreement he and Dr. A.K. had signed in May 1994, he never heard back from the Board as to whether it had approved or disapproved the agreement. He nevertheless was able to have Dr. A.K. begin the monitoring within a month of submitting the agreement, and the first report was timely issued on July 15, 1994. It is respondent's contention that he proceeded in good faith, without guidance or instruction from the Board, to timely obtain a monitor. He did obtain a monitor and has cooperated fully with the monitoring. Respondent argues that the charge of

professional misconduct should be dismissed.

I agree with the respondent that this charge of professional misconduct should be dismissed. Professional misconduct has not been specifically defined in the statutes or regulations governing the medical profession but has been addressed to some extent in the case law. The courts have rejected the argument that unprofessional conduct is punishable only if specifically proscribed by statute or regulation. In re Polk License Revocation, 90 N.J. 550 (1982); In re Suspension of Heller, 73 N.J. 292 (1977) [FN1]. The physician in Polk sexually abused an adolescent patient under the guise of treatment which the Court found constituted gross malpractice. Polk, supra, 90 N.J. at 574. In rejecting the physician's claim that the statutory standards were vague, both as written and in their application to his conduct, the Court, revisiting Heller, stated that (i)t has never been necessary for the Legislature to define with particularity acts which would constitute unprofessional conduct; ... and ... since it would be impracticable for the Legislature to catalogue and specify every act or course of conduct that would constitute such offenses as "bad moral character" and "unprofessional and dishonorable conduct," a doctor's license could also be revoked for having committed a nonspecifically enumerated act of unprofessional conduct. (Ibid. (citations omitted).)

In other words, even though a statute or regulation may enumerate certain acts and classify same as unprofessional conduct, the Legislature " did not thereby intend to exclude all other acts or conduct in the practice of the healing arts which by common understanding render the holder of a license unfit to practice." Heller, supra, 73 N.J. at 299 (quoting Kansas State Bd. of Healing Arts v. Foote, 200 Kan. 447, 436 P.2d 828 (Sup. Ct. 1968))(emphasis in Heller).

For example, Heller pointed to a case where a doctor's license was revoked for his having participated in a scheme to sell medical licenses. Heller, supra, 73 N.J. at 300 (citing State ex rel. Lentine v. State Bd. of Health, 334 Mo. 220, 65 S.W. 2d 943 (Sup. Ct. 1933)). Though not specifically enumerated in the relevant statute, the conduct was deemed unprofessional. Ibid. The Court determined that the "need for special identification does not exist in respect to conduct inherently wrong and obviously "unprofessional'." Id. at 306; see also, In re Suspension of License of Silberman, 169 N.J. Super. 243, 253 (App. Div. 1979) (where court found that evidence established that podiatrist who billed for services which were not performed and performed services which were neither required or requested, engaged in unprofessional conduct).

It appears that a common sense approach should dictate any determination as to what constitutes unprofessional conduct. It is also apparent that the conduct need not be specifically related to medical treatment or diagnosis. Had Dr. Brigham purposefully ignored the Board's order to obtain a monitor, with no intention of complying, I believe such defiance would be inherently wrong and obviously unprofessional. However, that is not what happened. Dr. Brigham appropriately inquired as to what was expected of him and was told by counsel for the Board that he would be told. He heard nothing until he received the written order. He in good faith expended considerable effort finding people willing to serve as an abortion practitioner's monitor. Eventually Dr. A.K. agreed, and he began monitoring as soon as he was able.

I FIND that Dr. Brigham intended to proceed expeditiously and in good faith to timely comply with the Interim Order of the State Board of Medical Examiners, announced orally on December 23, 1993, and issued in writing on February 7, 1994, which in part required him to secure the services of a supervisor acceptable to the Board who would review his records and file monthly reports. I further FIND that Dr. Brigham's conduct concerning compliance with the Interim Order did not constitute professional misconduct. Thus, I CONCLUDE that respondent's conduct did not constitute grounds pursuant to N.J.S.A. 45:1-21(e) for the suspension or revocation of his license to practice medicine and surgery in this State.

Motion to Impose Sanctions Based on the New York Revocation, pursuant to N.J.S.A. 45:1-21(g) (Third Complaint)

As noted above, the complainant filed another complaint with the Board ("Third Complaint") on December 2, 1994, also seeking sanctions against the respondent, based upon the allegation that the respondent's license to practice medicine in the State of New York had been revoked by the New York State Department of Health Administrative Review Board for Professional Medical Conduct. By Order effective December 14, 1994, the Board accepted respondent's offer to cease practicing in New Jersey and declined to then impose revocation of respondent's license based on New York's action, pending the New Jersey administrative law proceeding. On March 9, 1995, the New Jersey Board transmitted this third complaint to the Office of Administrative Law for determination as a contested case. The complainant moved for consolidation with the earlier matters and also moved for partial summary decision and other relief. The respondent opposed the application and by cross-motion sought an order to dismiss the latest complaint. The motion for consolidation was granted on the record on May 26, 1995, pursuant to N.J.A.C. 1:1-17.3. However, ruling on the remainder of the motions was deferred until completion of the evidentiary record, based on the Board's ruling of December 14, 1994.

Complainant asserts that the New York decision and order finding respondent to have engaged in gross and repeated acts of negligence resulting in direct and substantial patient harm should be adopted here as expressly permitted by N.J.S.A. 45:1-21(g). Complainant further asserts that the New York decision and order should form the basis for a disciplinary sanction regarding patients M.B. and A.W., since the New York authorities took final action against Dr. Brigham's license there based on his treatment of those two patients.

N.J.S.A. 45:1-21 provides:

A board ... may suspend or revoke any ... license issued by the board upon proof that the ... holder of such ... license

* * *

c. Has engaged in gross negligence, gross malpractice or gross incompetence;

d. Has engaged in repeated acts of negligence, malpractice or incompetence;

* * *

g. Has had his authority to engage in the activity regulated by the board revoked or suspended by any other state or authority for reasons consistent with this section;

* * *

It is the complainant's contention that the facts and conclusions set forth in the New York final order amply establish that in his care of patients M.B. and A.W., respondent engaged in gross negligence and negligence on repeated occasions. The revocation in New York is thus for reasons consistent with the grounds for revocation stated in N.J.S.A. 45:1-21(c) and (d). Therefore, the Board may take disciplinary action against respondent under N.J.S.A. 45:1- 21(g), based solely upon the revocation in New York. Matter of Cole, 194 N.J. Super. 237 (App. Div. 1984).

Respondent objects to application of N.J.S.A. 45:1-21(g), or collateral estoppel, and urges that the third complaint be dismissed. He has recited at length the procedural history of the complaints and proceedings against him, and argues that it is clear the Board has elected to exercise independent judgment in determining the facts for itself, rather than relying on the New York proceeding.

In particular, when the question of the New York revocation was directly before the Board on December 14, 1994, the Board declined to make any determination upon the complainant's application to impose discipline based on the New York action, instead accepting Dr. Brigham's offer to cease practicing medicine and surgery in New Jersey until the Board has had the opportunity, after review of the record, to accept, reject, or modify the initial decision of the administrative law judge and issue its own final order in this matter. Respondent notes that the obvious result of the Board's action in December 1994 was a full adjudication in this proceeding of the allegations concerning the two patients who were also the subject of the New York proceeding. Having allowed the adjudication on the allegations concerning M.B.

and A.W. to continue to completion, it would be inequitable and fundamentally unfair for the Board to now foreclose consideration of those proofs and instead sanction respondent based upon New York's determination.

I agree with the respondent. While the New York revocation is for reasons consistent with N.J.S.A. 45:1-21(c) and (d), application of N.J.S.A. 45:1-21(g) in this matter would be both unfair and anomalous. Unlike Matter of Cole, supra, the issues concerning M.B. and A.W. have been fully litigated here. There will be no savings of time or expense available by relying on the New York result. More important, however, is the result itself. With regard to the allegations concerning patients M.B. and A.W., the complainant here failed to meet her burden of persuasion. It would be grossly unfair to nevertheless sanction respondent in New Jersey because the New York forum reached a different conclusion. An administrative agency, in determining how best to effectuate public policy, must apply principles of fundamental fairness. State Dept. of Envir. Protection v. Stavola, 103 N.J. 425, 436 n.2 (1986); In re Arndt, 67 N.J. 432 (1975). Accordingly, I CONCLUDE that the complainant's motion for partial summary decision or collateral estoppel should be denied, and the respondent's cross-motion for dismissal of the third complaint should be granted.

SUMMARY

As fully described above, complainant has sustained her burden of persuasion as to the allegations remaining in Count X of the Amended Complaint and Count III of the Second Complaint, which concern misleading advertising. Respondent shall not place any advertisements which mislead or have the capacity to mislead, as determined by prior approval of the Board.

All other allegations of violations of the laws and regulations of New Jersey should be dismissed, for the reasons stated above. In short, the evidence against the respondent is insufficient to stand as a basis to bar Dr. Brigham from performing first trimester abortion procedures in New Jersey. Respondent voluntarily ceased practice in New Jersey in December 1994. He should now be permitted to resume practice, in accordance with all applicable laws and regulations.

It is so ORDERED.

I hereby FILE my initial decision with the BOARD OF MEDICAL EXAMINERS for consideration.

This recommended decision may be adopted, modified or rejected by the BOARD OF MEDICAL EXAMINERS, which by law is authorized to make a final decision in this matter. If the Board of Medical Examiners does not adopt, modify or reject this decision within forty-five (45) days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen (13) days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the EXECUTIVE DIRECTOR OF THE BOARD OF MEDICAL EXAMINERS, 140 East Front Street, 2nd Floor, Trenton, New Jersey 08608, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

FINAL AGENCY DECISION

JOHNSON, President:

This matter commenced with the filing of a Verified Complaint and order to Show Cause by the Attorney General of New Jersey against respondent, Steven Chase Brigham, M.D. on November 24, 1993. The Verified Complaint alleged, among other things, that respondent violated board regulations by performing second trimester abortions at a New Jersey office, that his treatment of four patients who sought

abortion services constituted gross malpractice, gross negligence and/or repeated negligence or incompetence in violation of N.J.S.A. 45:1-21, and that he posed a clear and imminent danger to the public health, safety and welfare, thus warranting imposition of an immediate temporary suspension. Respondent's answer to the complaint essentially denied all allegations of negligence and malpractice and asserted that his conduct was consistent with accepted standards of care.

Following a hearing held on an application for temporary suspension in December of 1993, the Board issued an Interim Order finding that as Dr. Brigham's unrestricted practice palpably demonstrated a clear and imminent danger to the public, his practice must be limited. The restrictions included a bar on his initiation or participation in second trimester abortions, (encompassing but not limited to the insertion of lamanaria in patients for purposes of cervical dilatation preceding evacuation of the uterus); and included his retention of a supervisor to review his patient records and to assure respondent's compliance with New Jersey law and the restrictions imposed.

The Attorney General filed a second Order to Show Cause and Verified Complaint in July 1994 seeking to temporarily suspend the license held by respondent. The complaint alleged that the care rendered to two abortion patients constituted gross and/or repeated malpractice or incompetence in violation of N.J.S.A. 45:1-21. Again, respondent's answer essentially denied the allegations of the complaint.

Following a hearing on August 1, 1994 a committee of the Board of Medical Examiners denied the application of the Attorney General to temporarily suspend Dr. Brigham's license and declined to find a clear and imminent danger to the public in the continuation of Dr. Brigham's practice under the restrictions previously imposed by the Board. Motions to accept and reject the committee's recommendations failed to attract a quorum of the Board at its meeting of August 19, 1994 and a further request of the Attorney General to have the matter considered at the Board's September meeting was tabled. No further action was taken.

The matter was referred to the Office of Administrative Law and an Initial Decision was rendered on April 12, 1996. [FN1] The Attorney General requested a 60-day extension of time through June 24, 1996 for the filing of exceptions. The extension was granted without objection of respondent. Simultaneously, the Board granted respondent's request, with the consent of the Attorney General, to his re-entry into the practice of medicine, pending the issuance of a final decision by the Board of Medical Examiners. The reinstatement of respondent's license was subject to the condition that he limit his performance of abortions in the State of New Jersey to first trimester abortions. Following additional extensions of time for the filing of exceptions, this matter was scheduled for final disposition before the Board of Medical Examiners on August 14, 1996.

At the hearing before the Board, the respondent appeared with counsel, Nathan L. Dembin, Esq. Jeri L. Warhaftig, Deputy Attorney General, represented the complainant.

Based on due consideration of the Administrative Law Judge's decision and the underlying record in this case, and upon the arguments of counsel, the Board adopts as its final decision the findings of fact and conclusions of law of the Administrative Law Judge [FN2]. Thus the Board upholds the ALJ's findings dismissing all allegations in the complaint except Count X of the Amended Complaint and Count III of the Second Complaint concerning misleading advertisement. The Board notes that in authorizing the initiation of a disciplinary action, the Board determined that sufficient cause existed for a full evidentiary determination in this matter. Similarly, following hearing regarding temporary suspension, the Board determined that sufficient cause existed to restrict respondent's license until conclusion of the plenary proceedings. However, upon review of the record of the plenary hearing in this matter, the Board adopts the decision dismissing the bulk of the allegations.

In considering the penalty to be imposed in this matter, the Board afforded both respondent and complainant the opportunity to present mitigating circumstances or

make further argument beyond that contained in their written exceptions. Both counsel declined the opportunity for further argument. The Board modified the penalty recommended by the ALJ to eliminate the requirement that respondent must obtain prior approval of the Board for all advertisements to prevent those which mislead or have the capacity to mislead. The penalty is modified to provide that respondent shall in the future cease and desist utilizing either the term "safe" or the term "painless" in any advertising, and shall cease and desist from any advertisements which mislead or have the capacity to mislead as prohibited by N.J.A.C. 13:35-6.10(c) and N.J.S.A. 45:1- 21(b). The Board believes that the requirement of the ALJ that respondent obtain from the Board pre-approval of all advertisements is unnecessary in the circumstances presented in this case.

Therefore, it is on this 28th day of August, 1996, nunc pro tunc August 14, 1996, ORDERED:

1. Respondent shall cease, desist and refrain from any and all advertising which misleads or has the capacity to mislead, and shall cease, desist and refrain from utilizing the term "safe" or the term "painless" in any advertising.
2. All counts of the complaints filed against respondent with the exception of Count X of the Amended Complaint and Count III of the Second Complaint are dismissed.
3. Respondent's license to practice medicine and surgery in the State of New Jersey is fully reinstated effective August 14, 1996.

FN1. In December of 1994, following commencement of the hearing in this matter, a third complaint was filed alleging that respondent's license to practice medicine and surgery was revoked in the State of New York for gross negligence in respondent's care of patient M.B. (whose care was the subject of Count I of the Attorney General's complaint in New Jersey) and gross and repeated acts of medical negligence in his care and treatment of A.W. (Count III of the Attorney General's complaint in New Jersey). Respondent's answer asserted that the New York decision was not final and that the decision was fundamentally flawed. Upon the Attorney General's application to suspend or revoke respondent's license based on the New York action, the Board declined to make any determination, and accepted respondent's offer to cease practicing medicine and surgery in New Jersey until the Board had an opportunity to consider the initial decision of an administrative law judge in this matter.

FN2. Thus the Board has denied the State's application to afford collateral estoppel effect to the disciplinary action of a sister state (N.Y.) regarding the same incidents involved in two counts of the complaint. However, the Board reaffirms the continuing applicability of that doctrine and its history of applying it and in taking action based on the suspension or revocation of a license in another state, in virtually all circumstances, and its intent to do so in the future. However, in the unique circumstances of this matter, the Board has chosen to review the entire record of the proceedings below.

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