1986-0515-001-056
Lic No: 21734

STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

In Re: Hanan Rotem, M.D.

NOTICE OF FINAL DECISION

TO: Hanan Rotem, M.D.

Lic #21734

Attached please find the final decision of the Connecticut Medical Examining Board in the above-referenced matter. The Board adopted the proposal for decision of the hearing panel with the following substantive amendment:

The second sentence of the last paragraph of page 4 was modified to state: "However testing a patient's hematocrit level prior to the procedure is essential in that such a test will present a baseline from which a physician can judge whether or not to do the procedure and, if so, how best to respond to post-procedure bleeding which may occur. See Record, Transcript, February 23, 1988, at 84, Transcript, November 22, 1988 at 64-66."

The Board also added language on page 10 indicating that the Board's expertise was utilized in the decision making process and that no extra-record evidence was considered.

Connecticut State Medical Examining Board

12/19/89
Date

By: Richard M. Ratzan, M.D.
Chairman

cc: Raymond B. Green, Esq.
Judith Lederer, Esq.

STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

In Re: Hanan Rotem, M.D.

FINAL DECISION

I. FACTS

1. Respondent Hanan Rotem, M.D. was at all pertinent times licensed in the practice of medicine and surgery by the State of Connecticut, Department of Health Services.

2. Prior to the initiation of the instant charges, the Respondent was given the opportunity to show compliance with all lawful requirements for the retention of his license pursuant to Conn. Gen. Stat. § 4-182(c). Record, Ex. D-1.

3. The Department of Health Services presented the Board with a Statement of Charges issued on October 19, 1987, alleging violations of Conn. Gen. Stat. § 20-13c(4) in Counts One and Two, and a violation of Conn. Gen. Stat. § 20-13c(4) and/or § 20-13c(7) in Count Three. Record, Ex. D-1.

4. A hearing on the charges was held on December 15, 1987, February 23, 1988, June 14, 1988, July 25, 1988, September 20, 1988, November 22, 1988 and December 13, 1988.

5. Respondent admits paragraphs one through four of the First Count. He admits paragraph five of the First Count with the exception that the word "extraction" should replace the word "curettage". He admits paragraph six of the First Count with the stipulation that the perforation of the uterus was not the cause of the patient's death. He admits paragraph seven of the First Count, but states specifically that amniotic fluid embolism was the cause of the patient's death. The Respondent denies

all other allegations in the Statement of Charges. Record, Answer of Hanan Rotem, M.D., dated November 2, 1987.

6. Items (c), (d), (e), (n) and (p) of paragraph 8 of the First Count were withdrawn by the Department.

7. Respondent was present, with counsel, at the hearing.

8. Before performing the abortion procedure at issue, the Respondent did not test the patient's hematocrit level or Rh factor. Record, Transcript, February 23, 1988 at 16, 27.

9. Neither of the two individuals employed in Respondent's Stamford, Connecticut office on April 29, 1986 had any formal medical training, nor had either been trained to monitor a patient's vital signs or to perform cardio-pulmonary resuscitation. Record, Transcript, February 23, 1988 at 17, Transcript, June 14, 1988 at 17.

10. During the course of preparing for and/or performing the cited abortion procedure, one of the two individuals so employed assisted in administering nitrous oxide, to induce conscious sedation, and observed the patient. Record, Transcript, February 23, 1988 at 18-19, Transcript, June 14, 1988 and 134, 140.

11. Respondent did not conduct an ultrasound examination of the fetus prior to performing the abortion at issue. Record, Transcript, February 23, 1988 at 16.

12. Respondent did not use laminaria to dilate the patient's cervix for purposes of the abortion. Record, Transcript, February 23, 1988 at 17.

13. Respondent did not have privileges at any Connecticut hospitals, nor did he have any written agreement with local health care providers for patient transfer or back-up care in the event of emergencies or complications. Record, Transcript, February 23, 1988 at 19.

II. DISCUSSION AND CONCLUSIONS

A. As to Respondent's Motion to Dismiss the Charges

Respondent filed a Motion to Dismiss the Charges on December 11, 1987, on which the Board reserved a ruling. For the following reasons, the Respondent's motion is denied:

1. Conn. Gen. Stat. § 20-13d does not require that a petition be filed prior to the Department's initiation of an investigation or issuance of a statement of charges. Conn. Gen. Stat. § 19a-14(a)(10) provides broad authority for the Department's investigation of possible violations of law, without restriction by sec. 20-13d.

2. As to the Department's procedure in determining probable cause pursuant to Conn. Gen. Stat. § 20-13e: a. Respondent's claim that he was not properly informed of the investigation fails. No statutory requirement for notification to the Respondent of the intitiation or pendency of an investigation is found in sec. 20-13e(a). It is undisputed that a compliance conference was held prior to the issuance of a Statement of Charges, which was duly received and answered by the Respondent, all evidencing the sufficiency of notice. b. Any and all authority to act under Conn. Gen. Stat. § 20-13e extends to the Department, rather than to the Commissioner in particular, or to any other specific individual within the Department. No unlawful delegation of power is indicated by the Department's pursuit of the instant charges as evidenced on the record (Transcript, December 15, 1987 at 72-126). c. No probable cause finding under sec. 20-13e is required when the investigation is initiated by the Department itself rather than pursuant to a petition filed under sec. 20-13d. Alternatively, any procedural defect in the Department's determination of probable cause is mooted by the facts elicited at hearing and now made the subject of this decision of the Board.

3. The Respondent's claims against the merits of the Department's probable cause finding are rendered moot by the Board's hearing of this case. The Respondent has had a full opportunity to present defenses to each allegation of wrongful conduct. Based upon relevant factual evidence and expert testimony which has now been presented before the Board, and judged for its credibility and significance, the instant decision represents a proper determination of the merits of this proceeding.

B. First Count

Respondent is charged with having violated Conn. Gen. Stat. § 20-13c(4), which provides:

> The board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician in accordance with section 19a-17, when the board finds that such physician is unable to practice medicine with reasonable skill or safety for any of the following reasons: ... illegal, incompetent or negligent conduct in the practice of medicine ....

1. As to Paragraph 8(a):

Respondent is alleged to have "failed to properly and safely manage and/or perform the second trimester abortion of Gloria Aponte [in that] he failed to order and/or perform appropriate blood work prior to the abortion procedure."

Expert testimony presented on this allegation revealed that the Respondent's practice of testing a patient's Rh factor after the abortion procedure, rather than before, was acceptable from a medical standpoint. However, testing a patient's hematocrit level prior to the procedure is essential in that such a test will present a baseline from which a physician can judge whether or not to do the procedure and, if so, how best to respond to post-procedure bleeding which may occur. See Record. Transcript, February 23, 1988 at 84, Transcript, November 22, 1988 at 64-66.

The Board finds that Dr. Rotem took inadequate precautions against potential medical complications, evidenced here by his failure to conduct a hematocrit test prior to the abortion procedure. A physician's knowledge of the pre-operative blood reserve of his patient may be essential in properly managing subsequent bleeding. Record, Transcript, February 23, 1988 at 84. To postpone hematocrit testing until after the procedure may complicate a physician's obligations at a point when control of heavy bleeding demands his strict attention. The Board concludes that the Respondent is guilty as charged in paragraph 8(a).

2. As to Paragraph 8(b):

The evidence on the record establishes no requirement in the practice of medicine for a physician to conduct an ultrasound examination of a fetus prior to performing an abortion, unless the physician is alerted by his own examination of the patient to a medically significant gestational age discrepancy. None of the expert witnesses who testified presented the Respondent's failure to conduct an ultrasound in this case as a violation of any standard of care.

3. As to Paragraph 8(f):

The Department presented expert testimony characterizing the use of laminaria in abortions as "easier" and "less painful" than dilatation. The relative ease of the procedure contributes to added safety, according to this testimony. Record, Transcript, February 27, 1988 at 88-89. However, no evidence on the record supports the Department's contention that the failure to use laminaria to dilate the patient's cervix constituted illegal, incompetent or negligent conduct in the practice of

medicine. On the contrary, a qualified physician's use of laminaria is a matter of preference, which the Respondent "might consider in the future," according to the Department's expert. Id., at 88-89, 107.

4. As to Paragraph 8(g) and (i):

Respondent is claimed to have "failed to properly and safely manage and/or perform the second trimester abortion of Gloria Aponte [in that] [(g)] he employed an individual with insufficient medical training to assist him during the abortion procedure, and [(i)] he failed to employ adequately trained office personnel who could assist him in the event of a medical emergency." The Board views these charges as concerning one inseparable issue; i.e., the adequacy of training for assisting personnel.

Evidence on the record establishes that the Respondent employed an untrained assistant for medical care purposes including administering nitrous oxide at the Respondent's direction, and monitoring patients' general condition during and after abortion procedures. Record, Transcript, June 14, 1988 at 127-159. Without the benefit of medical training, the Respondent's assistant was unable to identify operative functions of the nitrous oxide administration equipment, or to measure normal respiration, pulse, or blood pressure. Record, Transcript, June 14, 1988 at 143-4. Despite her duties, she was no more capable to assist with patients than any lay person.

Expert witnesses testified to the advisability and rationale for having trained staff assist in abortion procedures. Record, Transcript, February 23, 1988 at 90, Transcript, July 25, 1988 at 226-7, 365-7. Even the Respondent acknowledged the value of trained staff in outpatient abortion facilities. Record, Transcript, February 23, 1988 at 60.

In view of the assigned duties of Respondent's assistant, the Board finds that his failure to assure the assistant was trained to recognize problems with the administration of nitrous oxide, or changes in a patient's medical condition, jeopardized the patient's immediate safety during the abortion procedure. The Respondent's reliance on untrained personnel to assist during abortion procedures was misplaced. As the assistant was unprepared to competently observe or measure and report the patient's overall medical condition, the Respondent's ability to safely manage potential complications or emergency circumstances was compromised.

By its determination on this count, the Board does not speak to the issue of a physician's reliance on trained and qualified health personnel. Clearly, however, the attending physician in the circumstance of this case is responsible for all aspects of abortions he performs. By virtue of the Respondent's employment and reliance upon untrained assisting personnel, as evidenced on the record, the Board concludes that Respondent is guilty as charged in paragraph 8(g) and (i) of the First Count.

5. As to Paragraph 8(h), (j), (k), (l), (m) and (o):

The substantial evidence on the record will not support a conclusion that the Respondent employed anesthesia, as charged in paragraph 8(h), rather than analgesia, in the course of the abortion procedure at issue. While asserting that nitrous oxide can be administered in both analgesic and anesthetic levels, the Department's first ob./gyn. expert deferred to the opinions of qualified anesthesiologists as to its appropriate use and administration. Record, Transcript, February 23, 1988 at 106. Its second such expert also declined to comment on any differences between a conscious analgesic and an anesthetic. Id. at 140. Its anesthesiologist expert testified that there is no such

distinction with regard to nitrous oxide. Record, Transcript, July 25, 1988 at 169; however, the Respondent's expert, of equal credibility, characterized nitrous oxide primarily as an analgesic. Record, Transcript, November 22, 1988 at 10-17.

The record does not establish that the Respondent "failed to properly monitor Gloria Aponte's vital signs" as alleged in paragraph 8(k). As to his method of monitoring the patient's conditions, the record supports the propriety of verbal monitoring. Record, Transcript, September 20, 1988 at 510, November 22, 1988 at 17. While there is some question of the sufficiency of communications between Respondent or his assistant and his patients (see Record, Transcript, June 14, 1988 at 134, 139), the use of verbal monitoring as a method of procedure does not violate Conn. Gen. Stat. § 20-13c(4).[1/] Conflicting expert opinions on the Respondent's specific practices in monitoring vital signs during the abortion procedure failed to establish negligence or incompetence as charged. See Record, Transcript, July 25, 1988 at 226; Transcript, September 20, 1988 at 510; Transcript, November 22, 1988 at 77, 226.

According to the evidence presented, Respondent's failure to have privileges at any Connecticut hospitals, or written arrangements for patient transfer or back-up care (paragraph 8(m)), did not constitute negligent or incompetent practice, in view of his Connecticut office's proximity to a New York hospital where he had privileges, and the availability of emergency services nearby. Record, Transcript, February 23, 1988 at 94, November 22, 1988 at 82. Finally, no evidence on the record supports that Respondent failed to properly manage and/or control Gloria Aponte's blood loss, as charged in paragraph 8(o).

1/ The Board's finding that verbal monitoring is not in itself negligent or incompetent practice is distinguished from its determination above that his assistant's training was inadequate for the duties assigned to her.

C. Second Count:

The Board finds paragraph 8(a), (b) and (c) to be repetitious of the charges in Count One, and therefore dismisses these charges.

As to paragraph 8(d), the Board finds no evidence to support the charge that the Respondent failed to render proper emergency care in this case.

D. Third Count:

No evidence was presented in support of the Third Count; therefore, no statutory violation as alleged therein is found.

III. ORDER

After consideration of the matter in accordance with the provisions of Conn. Gen. Stat. § 4-179 and under the authority granted by Conn. Gen. Stat. § 19a-17, the Board hereby issues the following order:

1. A letter of reprimand shall be issued by the Board to the Respondent;

2. The Respondent is assessed a one thousand dollar ($1,000.00) civil penalty for the violation as charged in paragraph 8(a) of the First Count, and a single one thousand dollar ($1,000.00) civil penalty for the inadequacies in training of assisting personnel, as charged in paragraph 8(g) and 8(i). The total civil penalty of two thousand dollars ($2,000.00) is to be paid by certified check, made out to Treasurer, State of Connecticut, and mailed or delivered to:

State of Connecticut
Department of Health Services
Hearing Office
150 Washington Street
Hartford, Connecticut 06106

3. The final decision shall be effective, and the civil penalty paid in full, forty-five (45) days from the date of its mailing to the Respondent.

This decision is based exclusively on the evidence in the record as well as the Board's expertise in evaluating charges against physicians and the requisite standard of care by which to judge such charges.

Connecticut State Medical
Examining Board Panel

12/19/89
Date

By: R M Ratzan MD
Richard M. Ratzan, M.D.
Chairman

December 22, 1989
Date of Mailing to
Respondent

Celia B. Carroll
Celia B. Carroll
Board Liaison

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

Rec'd 7-20-90 JB

TO: [redacted]
Joseph J. Gillen, Section Chief, APEX
David J. Pavis, Section Chief, PHHO
Lynne Hurley, MQA Investigator, PHHO

FROM: Celia B. Carroll, Board Liaison

RE: Hanan Rotem, M.D.

DATE: July 19, 1990

This memo is to inform you that the forty-five day appeal period in the above-captioned matter expired on February 5, 1990. The Respondent did not file an appeal of the Board's decision. The decision is effective, therefore, at the expiration of the appeal period.

Please do not hesitate to contact me if you have any questions.

CBC:cb

Phone:
150 Washington Street — Hartford, Connecticut 06106
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