STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

June 18, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Diane Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

David N. Wynn, Esq.
Arent, Fox, Kintner, Plotkin
& Kahn, PLLC
1675 Broadway – 25th Floor
New York, New York 10019-5874

Joel Novendstern, M.D.
47 Todd Road
Katonah, New York 10536

RE: In the Matter of Joel Novendstern, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-156) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

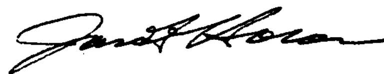
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

------------------------------X

IN THE MATTER

OF

JOEL NOVENDSTERN, M.D.

------------------------------X

ORDER #

BPMC #03-156

COPY

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **JAMES DUCEY**, Chairperson, **PASCAL IMPERATO M.D.** and **MADGY MIKHAIL M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by Joel Novendstern M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

SUMMARY OF PROCEEDINGS

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, N.Y.

Pre-Hearing Conference:		February 20, 2003
Hearing dates:		March 4, 2003 April 14, 2003 April 15, 2003 April 21, 2003
Dates of Deliberation:		May 13, 2003
Petitioner appeared by:	by:	NYS Department of Health Diane Abeloff, Esq. Assistant Counsel
Respondent appeared:	by:	Arent Fox Kintner Plotkin & Kahn, PLLC 1675 Broadway - 25th Floor New York, N.Y. 10019-5874 Jeffrey R. Ruggiero Esq and David N. Wynn Esq.

WITNESSES

For the Department:	Roy Schoen M.D. Pauline Hibbert R.N. Gerald Costa M.D.
For the Respondent:	Mark Gray M.D. Joel Novendstern M.D. Frederick Clare M.D. Nereida Correa M.D. Ray Mercado D.O.

SIGNIFICANT LEGAL RULINGS

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct. The Administrative Law Judge issued instructions to the Committee when asked regarding the definitions of medical misconduct as alleged in this proceeding.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

FINDINGS OF FACT

1. The Respondent is authorized to practice medicine in New York State on or about September 30, 1976 by the issuance of license number 128250 by the New York State Education Department.

2. Respondent worked at a medical facility at 2070 Eastchester Road, Bronx, N.Y. on December 13, 2000.

PATIENT A

3. Pt. A came to the Respondent's office on December 13, 2000 for a termination of pregnancy. The gestational age of the fetus was 23 weeks and five days. (Pet. Exh. 3; T. 22)

4. The nurse placed laminaria in Patient A's cervix on December 14th. Patient A returned to the office the following day when more laminaria were inserted by the nurse. The third day, December 16, 2000, Respondent first treated Patient A in the operating room at a Bronx, NY clinic

before the termination of pregnancy on or about 10:05 a.m. Respondent terminated the pregnancy through the technique of dilation and evacuation (Pet. Exh. 3; T. 22, 34)

5. Respondent maintained a mental count of the parts as he removed them. (Pet. Exh. 3; T. 650)

6. Respondent suspected he had perforated the uterus when either the Bierer forceps or the curette went in too far into Patient A's uterine cavity. His knowledge of the perforation was reflected in his statement in Patient A's record, "an obvious perforation was felt." (Pet. Exh. 3; T. 42, 184, 191, 192, 209, 591, 599, 658-660, 714, 724)

7. Respondent performed a sonogram in the operating room. This sonogram showed that the uterus was empty. He transferred the patient to the recovery room. (Pet. Exh. 3)

8. When Respondent transferred Patient A to the care of Nurse Hibbert, the recovery room nurse, he told her to observe the patient for bleeding. (T. 240, 248, 250)

9. While in the recovery room, Patient A told Nurse Hibbert that she was in "....a lot of pain." Nurse Hibbert saw that Patient A "...was bleeding a lot." Nurse Hibbert reported this to Respondent who was in the operating room performing another abortion. (T. 241, 287)

10. At 11:00 a.m. Respondent ordered a second sonogram. This time he directed the sonographer to explore the abdomen since the patient was complaining of pain. (Pet. Exh 3; T. 73, 210, 214, 601, 728)

11. The 11:02 a.m. sonogram demonstrated that the fetal calvarium, 5.8 cm in size, was in the abdomen under the liver which meant there had to have been a perforation in the uterus at least 5.8 cm. (Pet. Exh. 3; T. 41, 46)

12. Once Respondent saw the sonogram, he recognized that the patient needed to be transferred immediately to the hospital. With a large perforation the patient can go into shock and bleed out. In addition, prior to the termination procedure, Patient A had a low hematocrit of 30. Any bleeding with this low hematocrit would have a significant impact on this patient. (Pet. Exh 3; T. 190, 194)

13. Respondent failed to call an ambulance. (Exh. 3)

14. Respondent roused Patient A to inform her of the complications and that she needed to go to the hospital. She was still groggy. Respondent did not think she understood; therefore, Respondent decided to speak to the patient's boyfriend. (T. 602, 603)

15. Respondent spoke to the boyfriend in a small private office in the clinic. Respondent told the boyfriend that there had been a complication and Patient A needed to be transferred to the hospital. The boyfriend requested that Respondent call Patient A's mother, which Respondent did. (Pet. Exh. 3; T. 603)

16. Respondent failed to sufficiently explain to the patient's boyfriend, or the mother, who was the designated emergency contact person the risks of taking Patient A in her condition in a private vehicle to the hospital.

17. The Respondent failed to accompany Patient A or provide medically trained personnel to accompany Patient A to the hospital when she was taken in a private car. (Pet. Exh. 3; T. 516, 706,712)

18. Respondent directed the recovery room nurse to get Patient A ready for transfer to a hospital via private car. The recovery room nurse removed the intravenous line because in her experience, a patient cannot be transported in a private car with an intravenous line running.

19. It was the Respondent's responsibility to assure that Patient A went to the hospital with venous access. (T. 52)

20. Respondent allowed Patient A to be driven to the hospital in a private vehicle without assuring venous access during the transportation. (T. 206, 245, 257, 259, 608, 609, 675, 676)

21. The boyfriend and Patient A left the clinic between 11:20 and 11:25 a.m. on December 16, 2000. The did not arrive at Jacobi Hospital until approximately 11:55 a.m. (Pet. Exhs. 3, 4; T. 613)

22. When Pt. A arrived at the hospital she was going into shock. Her blood pressure was 104 over 40, her pulse was 86, her temperature was 95.7. She had abdominal pain, she was pale and she quickly became lethargic and the pads were soaked with blood. (Pet. Exh. 4; T. 161, 162, 164, 295, 313, 316)

23. The Respondent's signed medical records with information placed in the Patient's medical chart prior to the Respondent seeing the Patient. (T. 631)

24. The Respondent failed to accurately record the care and treatment he rendered in the Patient's medical chart. (T. 619, 713)

DISCUSSION

The Panel considered all the testimony and evidence presented at the hearing.

Two Panel members found Respondent failed to call an ambulance after the second sonogram confirmed a perforation; an egregious act that placed Patient A in a life-threatening situation.

The Department's expert witness, Dr. Schoen testified that a person, such as Patient A, more than 23 weeks pregnant with a perforated uterus could "...exsanguinate in a rapid fashion...." and therefore should be immediately transferred to the hospital, optimally by an ambulance transfer. (T. 60, 193) Dr. Schoen opined that the reasons for transferring Patient A to a hospital were several. The Respondent suspected a perforation as indicated in his procedure note "...an obvious perforation was felt" (Dept. Exh. 3) and the Respondent would be unable to differentiate if the perforation is in the middle or in the lateral portion of the uterus. If it were a lateral perforation it could be fatal within a few minutes. Prior to the procedure, Patient A's hematocrit was low (30); any bleeding would have a severe impact on the patient. Patient A was seven centimeters dilated which would indicate that this was a perforation of considerable size. Finally, the clinic's fact sheet indicates that if there is a perforation, the patient would require hospitalization. (T. 190 - 196)

Respondent's expert witness, Dr. Gray testified that Patient A should be transported to the hospital by ambulance so that she could have medical personnel and equipment available for resuscitation in case she became hemodynamically unstable. (T. 514) Dr. Gray stated that shock can have a very rapid onset and the patient can go into cardiac arrest. (T. 515)

The Respondent testified that he had every intention of calling an ambulance. He went to speak with Patient A's companion and stated: "He prevented me from doing that. He was hostile, he was in my face, it was a small, small room. He was very, very, angry. He was angry at me." (T. 605) The majority of Panel members found the Respondent's testimony regarding the transfer to be not credible. The Respondent never attempted to call the security guard or the administrator. No one was requested to come to the Respondent's assistance. The Respondent failed to document this conversation in the Patient's chart. (T. 671 - 673) Respondent does not mention feeling threatened by Patient A's companion in his interview with OPMC. (T. 725)

Notwithstanding the Respondent's testimony on this issue, the Respondent's failure to call an ambulance prior to speaking with Patient's A's companion is a serious deviation from accepted medical standards. (T. 61) Both experts agree that Patient A needed to be transported to the hospital via ambulance.

Two of the Panel members found that the Respondent allowed Patient A to be driven to the hospital in a private vehicle without assuring venous access during the transportation to be gross negligence.

Dr. Schoen testified that young healthy people's vital signs are not always indicative of the serious physical state they are in. Sudden onset of shock can occur very quickly. A physician can anticipate that a patient that has a 5.8 centimeters perforation should be bleeding and if it's not visibly seen coming from the cervix, one should assume that the patient is bleeding internally. The patient could go into cardiac arrest and/or respiratory arrest. The patient could die. It is the Respondent's responsibility to insure that Patient A has an IV line. (T. 206) The IV line is the lifeline of such a patient through which to administer medications immediately. If the patient arrives at a hospital in a morbid state it is always harder to find a vein rather than have one that is in place. The failure to transfer Patient A to the hospital without an IV deviated from accepted medical standards. (T. 52 - 62)

Dr. Gray testified that having an IV would very instrumental to keeping the circulation and for resuscitation purposes. (T. 550) It is one way to assist a patient who might go into shock. (T. 524)

The Respondent testified that an intravenous line was very important for Patient A. (T. 676) He did not ensure that it remained in her arm. He stated that he did not order the nurse to remove it, however it's something that is done automatically when the patient is stable. (T. 676, 685) The Respondent was with Patient A when she went into the car and realized that she did not have the IV. The situation did not lend itself to a discussion. The time it would take to talk to the Patient's partner he felt would be considerable and the time would be better spent taking her to the hospital. (T. 711)

The majority Panel members felt that the Respondent's failure to ensure Patient A had IV access was a serious lapse in his judgment. Although he did not instruct the nurse to remove the IV, it was his responsibility to have Patient A leave with the IV. Patient A's medical record indicates that the Respondent signed the procedure note stating "IV removed." Respondent's awareness of the dangers for a patient who is more than 23 weeks pregnant with a perforation that was significant in size obligated him to assure the hospital would have immediate access to save her life. Both experts agree that Patient A should have left the clinic with IV access.

The Panel was unanimous in finding the Respondent had abandoned his care and treatment of Patient A by not assuring that she had IV access.

Dr. Costa, the subsequent treating ob/gyn found Patient A to be hypotensive, have tachycardia and subnormal temperatures pre-operatively. (T. 332) Dr. Costa testified that he intended to perform a laparotomy and to have a general surgeon present in case of need. There was an estimated blood loss of 2,500 cc's. (T. 334) The abdominal pelvic cavity was full of blood. (T. 334) The uterine laceration was 3 by 6 centimeters and bleeding. (T. 338) The calvarium was found near the liver. There was broad ligament injury, transverse colon injury and a retroperitoneal

hematoma. A cervical laceration was found post-operatively. Patient A was given 4 units of blood. Dr. Costa performed a supracervical hysterectomy on Patient A. (T. 341 - 355)

The Panel concluded that Patient A's chart is a sham, replete with inaccuracies. (T. 187, 516 - 518, 535 - 536, 548 - 550, 619, 631, 673)

There is no documentation of the size of the cervical diliatation. (T. 509) The form indicating the type of forceps used and tissue examination is not marked. (T. 197) If the portion of the form with the tissue examination had been checked, a missing calvarium would have been detected. If the form is not checked off it indicates that it wasn't done. (T. 198)

The physician's discharge note specifies that the discharge medication given to Patient A was Methergine and Ibuprofen 600 mg. If a patient is suspected of bleeding, Ibuprofen is contraindicated "...because they could bleed out." (T. 198 - 199)

The procedure note, signed by Dr. Novendstern states "IV removed" yet he testified he never directed Nurse Hibbert to remove the IV. The failure to include a date or time is a departure from the standard of care. (T. 188)

There is no record of the Respondent explaining to Patient A or her partner the risks of going to the hospital without an ambulance. (T. 516)

There is no record the Respondent reviewed or examined the fetal parts. (T. 518, 532) There is also no record the Respondent had questions about whether all of the fetal parts had been removed. (T. 534 - 535)

There is no indication in Patient A's record the time she left the clinic. (T. 543)

The procedure note has no date or time. (T. 546)

In Respondent's sworn statement he stated that another person completed the information on a "certificate of induced termination of pregnancy" and he signed it before it was completed. It was pre-signed because there is a stack of them that he signed in advance for the particular day. (T. 732)

The purpose of an accurate medical record is to provide an accurate description of events as they occur of how a patient is treated and provides reference points, which one can refer to. It is a historical document and if the patient needs further treatment it provides a source of information for the subsequent treating physicians. It is unacceptable to write notes prior to the procedure and to sign those notes prior to the procedure being performed. (T. 69)

The Panel reviewed all potential penalties. The Panel was unanimous in their decision on the penalty. The Panel found that the Respondent did not demonstrate a total willful disregard for the well-being of Patient A. His overall care of Patient A was acceptable. He sent the patient to the hospital, included a note from himself with his telephone number, called the emergency room and the chief resident. The penalty is based on the Respondent's lapse in judgment with regard to transporting Patient A to the hospital and his failure to secure her well-being until she was in the hands of another treating physician.

PANEL'S DETERMINATION ON THE CHARGES

GROSS NEGLIGENCE

Paragraphs A1, A2, A3, A4, A7, A8 – NOT SUSTAINED

Paragraphs A5, A6 - SUSTAINED by majority Panel members

Paragraphs A9 - SUSTAINED by majority Panel members

PATIENT ABANDONMENT

Paragraphs A 1, A7, A8 - NOT SUSTAINED

Paragraph A6 - SUSTAINED by unanimous Panel

MORAL UNFITNESS

Paragraph A1, A5 through A9 - NOT SUSTAINED

FAILURE TO MAINTAIN RECORDS

Paragraph A9 – SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

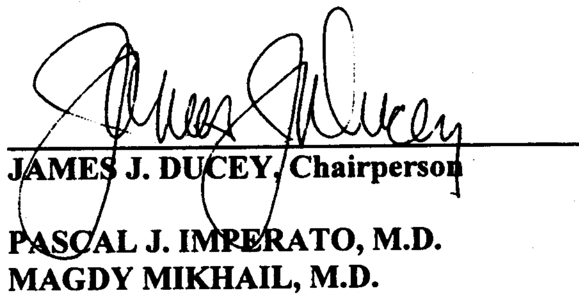
The Hearing Committee, unanimously, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the state of New York should be SUSPENDED FOR THREE YEARS, STAYED FOR TWO YEARS AND NINE MONTHS under the probation condition that the Respondent can only practice medicine in a medical hospital setting.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York should be SUSPENDED FOR THREE (3) YEARS, STAYED FOR TWO (2) YEARS AND NINE (9) MONTHS under the probation condition that the Respondent can only practice medicine in a medical hospital setting.
2. This ORDER shall be effective upon service on the Respondent or the Respondent's attorney by personal service or registered mail.

DATED: Kew Gardens, New York
June 12 , 2003



JAMES J. DUCEY, Chairperson

PASCAL J. IMPERATO, M.D.
MAGDY MIKHAIL, M.D.

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JOEL NOVENDSTERN, M.D.	STATEMENT OF CHARGES

JOEL NOVENDSTERN, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 30, 1976, by the issuance of license number 128250 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about December 16, 2000, Respondent, at his office located at 2070 Eastchester Road, Bronx, N.Y., performed a termination of pregnancy on Patient A. She was 23 5/7 weeks pregnant. The fetal head was retained after the procedure. Patient A went to Jacobi Hospital, Bronx, N.Y., where the physicians had to perform a supracervical hysterectomy. Respondent's care deviated from accepted medical standards, in that:

1. During the course of a termination procedure, Respondent perforated Patient A's uterus causing a 6 cm x 3 cm hole in her uterus.

2. Respondent failed to evaluate if he had removed all the products of conception prior to discharging the patient to the recovery room.

3. Respondent, suspecting a uterine perforation, failed to order a full abdominal/pelvic scan in the operating room prior to discharging the

patient to the recovery room.

4. Respondent, suspecting a uterine perforation, failed to instruct the recovery room personnel to increase their surveillance of Patient A.

5. Respondent, upon determining intra abdominal fetal parts and confirming a uterine perforation, failed to call an ambulance to transport the patient to the hospital.

6. Respondent allowed Patient A to be driven to the hospital in a private vehicle without assuring venous access during the transportation.

7. Respondent failed to accompany Patient A or provide medically trained personnel to accompany Patient A to the hospital when she was take in a private vehicle.

8. Respondent allowed Patient A to leave his office without advising her or her transporter of the increased risks of going to the hospital unaccompanied in a private vehicle.

9. Patient A's record failed to accurately reflect the care and treatment rendered.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in Paragraph A and its subparagraphs.

SECOND SPECIFICATION

PATIENT ABANDONMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(30) by abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, as alleged in the facts of:

2. The facts in Paragraph A and A 6, A7 and A8.

THIRD SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

3. The facts in Paragraph A and A 9.

DATED: January , 2003
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct