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

November 17, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

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

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

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

Dear Parties:

Enclosed please find the Determination and Order (No. 03-156) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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.

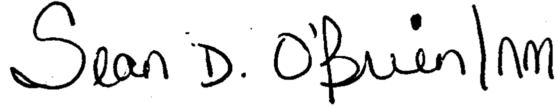
Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,



Sean D. O'Brien, Director
Bureau of Adjudication

SDO: nm
Enclosure

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

In the Matter of	
Joel Novendstern, M.D. (Respondent)	**Administrative Review Board (ARB)**
A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	**Determination and Order No. 03-156**

COPY

Before ARB Members Grossman, Lynch, Pellman and Briber[1]
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Dianne Abeloff**
For the Respondent: **David N. Wynn and Jeffrey R. Ruggiero**

After a hearing below, a BPMC Committee determined that the Respondent's treatment for a patient amounted to practice with gross negligence, that the Respondent abandoned the patient and that the Respondent failed to an maintain accurate record for the patient. The Committee voted to suspend the Respondent's New York medical license (License), to stay all but three months of the suspension and to limit the Respondent's practice for two years and nine months. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2003), both parties ask the ARB to reconsider the Committee's Determination on both the charges and on penalty. After reviewing the record and the parties' review submissions, we vote to affirm the Committee's Determination on the charges. We affirm the Committee's Determination to suspend the Respondent's License and to stay the suspension in part, but we modify the Determination to apply the stay to all but six months of the suspension. We affirm the Committee's Determination to limit the Respondent's License, but we modify the Determination and limit the Respondent's License permanently to practice in a general hospital.

[1] ARB Member Datta Wagle, M.D., was unable to participate in this case. The ARB proceeded to consider the case with a four member quorum, see Matter of Wolkoff v. Chassin, 89 NY2d 250 (1996).

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(4), 6530(30) & 6530(32) (McKinney Supp. 2003) by committing professional misconduct under the following specifications:

- practicing medicine with gross negligence;
- abandoning or neglecting a patient in need of immediate professional care, without making reasonable arrangements for the continuation of such care; and,
- failing to maintain accurate patient records.

The nine factual allegations (A1-A9) concerned the care the Respondent provided to a patient (Patient A) during and after a pregnancy termination procedure that occurred at the Respondent's office. The Respondent denied the charges and a hearing ensued before the Committee that rendered the Determination now on review.

The Committee found that the Respondent performed a procedure on Patient A at the Respondent's office and that the Patient's uterus became perforated during the procedure. The Committee found further that the Respondent realized that the Patient required transfer to a hospital, but that the Respondent failed to call an ambulance. The Respondent allowed the Patient's boyfriend to drive the Patient to the hospital in a private car. The Committee also found that the Respondent became aware that his nurse had disconnected the Patient's IV. The Committee made findings that the Respondent bore the responsibility to assure that the Patient went to the hospital with venous access, but that the Respondent allowed the Patient to leave for the hospital without venous access.

The Committee voted to sustain Factual Allegations A5, A6 and A9 that charged that the Respondent:

- failed to call an ambulance to take Patient A to the hospital (A5),

- allowed the Patient to be driven to the hospital without assuring venous access during transportation (A6), and,maintained records that failed to reflect the Patient's condition accurately (A9).

The Committee voted to dismiss Factual Allegations A1-A4 (concerning the procedure on the Patient), A7 (alleging failure to accompany the Patient to the hospital or provide medically trained personnel to accompany the Patient) and A8 (alleging that the Respondent allowed the Patient to leave the Respondent's office without advising the Patient about risks from transport in a private vehicle). In making their Determination on Factual Allegation A5, the Committee found that both the Petitioner's and the Respondent's expert witnesses agreed on the need to transport Patient A to a hospital. The Committee rejected the Respondent's explanation that the Respondent failed to call an ambulance because the Patient's boyfriend prevented the Respondent from making the call. The Committee found that the explanation lacked credibility, because the Respondent never made a request for assistance at the time, failed to document the conversation in the Patient's chart and failed to mention any threats by the boyfriend during the Respondent's interview with the Office for Professional Medical Conduct. In making their Determination on Factual Allegation A6, the Committee noted that the both experts agreed about the need for venous access during transportation, that the Respondent knew about the importance of the venous line and that the Respondent failed to ensure that an IV line remained in the Patient's arm. As to Factual Allegation A9, the Committee described the Patient's chart as a sham, replete with inaccuracies.

The Committee concluded that Factual Allegation A9 provided the basis on which to sustain the charge that the Respondent failed to maintain accurate records. Further, the Committee concluded that Factual Allegations A5, A6 and A9 provided the basis on which to sustain the charge that the Respondent practiced with gross negligence. The Committee also concluded that Factual Allegation A6 provided the basis to sustain the charge that the Respondent abandoned Patient A. The Committee dismissed the charge that the Respondent engaged in conduct that evidenced moral unfitness. The Committee voted to suspend the

Respondent's License for three years, to stay the suspension for all but three months and to place the Respondent on probation that restricts the Respondent's practice to a hospital setting.

Review History and Issues

The Committee rendered their Determination on June 18, 2003. This proceeding commenced on July 2 & 3, 2003, when the ARB received the Review Notices from the Petitioner and the Respondent. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the Respondent's response brief on August 27, 2003.

The Respondent argues that no grounds exist to support the Committee's Determination to sustain Factual Allegations A5 and A6 and that those Factual Allegations provide no basis to support a Determination that the Respondent practiced with gross negligence and abandoned Patient A. The Respondent conceded to poor record keeping, but argued that poor record keeping failed to justify a finding that the Respondent practiced with gross negligence or to justify the penalty that the Committee imposed.

The Petitioner argues that the Committee made a Determination inconsistent with their findings in dismissing Factual Allegations A1-A4, A7 and A8 and in dismissing the charge that the Respondent engaged in conduct that evidenced moral unfitness. The Petitioner asks that the ARB overturn the Committee, sustain additional Factual Allegations and the moral unfitness specification and overturn the penalty the Committee imposed. The Petitioner requests that the ARB revoke the Respondent's License, or in the alternative, that the ARB add standard probation terms to the penalty.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent failed to maintain an accurate record for Patient A, a misconduct violation under Educ. Law § 6530(32). We also affirm the Determination to sustain factual Allegation A9. The Respondent conceded that problems existed with his record keeping. We reject the requests by the Petitioner and the Respondent that we overturn the Committee's findings and conclusions on the other charges. We modify the Committee's Determination to suspend the Respondent's License by increasing the time the Respondent must spend on actual suspension. We modify the penalty further to place a permanent restriction on the Respondent's License to limit the Respondent to practice in a general hospital only.

We reject the Respondent's argument that no basis existed to sustain Factual Allegations A5 and A6. No factual dispute exists over whether the Respondent failed to call an ambulance and whether venous access existed during the Patient's transport to the hospital. The medical experts agreed about the need for an ambulance and for venous access. The Respondent also recognized the need for venous access and realized that a nurse had removed the Patient's IV. The Respondent faults the Committee for failing to accept the Respondent's explanations for his failures and the Respondent, in effect, asks the ARB to substitute our judgement on the Respondent's credibility for the Committee's judgement. We reject that request. We defer to the Committee in their judgement on credibility. We affirm the Committee's Determination to sustain Factual Allegations A5 and A6.

The Respondent also argued that A5 and A6 failed to provide a basis for sustaining the gross negligence specification and that A6 failed to provide a basis for sustaining the abandonment specification. To prove gross negligence, the Petitioner must prove either a single

act of negligence of egregious proportions or a pattern of negligent acts that amount to egregious conduct in the aggregate, Matter of Rho v. Ambach, 74 N.Y.2d 318 (1989). Further, proof that a physician sent a patient with severe bleeding to a hospital, in a vehicle other than an ambulance, without establishing an intravenous line, provides sufficient grounds to establish gross negligence, Matter of Schwalben v. DeBuono, 265 A.D.2d 609, 696 N.Y.S.2d 262 (3rd Dept. 1999). We agree with the Committee that the failure to call an ambulance and the failure to ensure venous access amounted to egregious conduct that placed the Patient in a life-threatening situation. We also agree with the Committee that the failure to ensure venous access during transport constituted abandoning or neglecting a patient in need of immediate professional care, without making reasonable arrangements for such care.

The Respondent also argued that his problems with record keeping failed to amount to gross negligence. After considering that challenge, two ARB members voted to affirm the Committee's Determination that the record for Patient A evidenced gross negligence and two members voted to overturn the Committee. Under Pub. Health Law § 230-c(4)(c), all ARB determinations require a majority, or three votes, Matter of Wolkoff v. Chassin, 89 N.Y.2d 250 (1996). As the ARB can make no Determination due to the tie vote, the Committee's Determination on that charge remains in place.

The Petitioner asked that the ARB overrule the Committee, sustain Factual Allegations A1-A4, A7 and A8 and find that the Respondent's conduct at issue in those Factual Allegations amounted to practicing with gross negligence. We vote 4-0 to affirm the Committee's Determination. We agree that the Respondent provided acceptable care prior to time he realized that the Patient was suffering severe bleeding. We also reject 4-0 the Petitioner's request that we

find that the Respondent's conduct evidenced moral unfitness. We agree with the Committee that the Respondent showed no willful disregard for the Patient's condition.

We reject the Petitioner's request that we revoke the Respondent's License. This constituted a single case, with a tragic result. We agree with the Committee, however, that the Respondent's conduct placed the Patient in a life-threatening situation and that the Respondent's errors warrant a severe sanction. Egregious misconduct, even involving a single patient procedure, can warrant a penalty that includes both an actual practice suspension and a permanent license restriction, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). We affirm the Committee's Determination to suspend the Respondent's License for three years and to stay that suspension in part, pursuant to Pub. Health Law § 230-a(2)(a). We modify the penalty to stay the suspension for all but six months, rather than all but three. The six months actual suspension will include the three months that the Respondent has served on suspension under the Committee's sanction. The Committee also limited the Respondent's License to practice in a hospital setting only for the two-half year period of the stayed suspension. We modify that sanction to make the limitation permanent. The Respondent's conduct in this case shows the ARB the Respondent's unfitness to remain in an office or private practice setting. The Respondent requires supervision and the quality control mechanisms in place in a "general hospital" under the definition for that term in Pub. Health Law § 2801(10):

10. "General hospital" means a hospital engaged in providing medical or medical and surgical services primarily to inpatients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to diseases, injuries and deformities. The term general hospital shall not include a residential health care facility, public health center, diagnostic center, treatment center, out-patient lodge, dispensary and laboratory or central service facility serving more than one institution."

The ARB votes 4-0 to place a permanent restriction on the Respondent's License, pursuant to Pub. Health Law §230-a(3), limiting the Respondent to practice in a general hospital.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

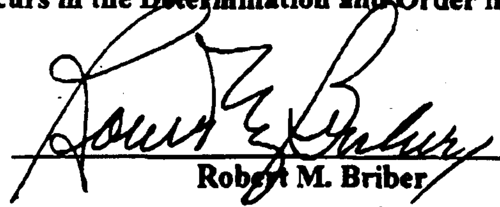
1. The ARB affirms the Committee's Determination that the Respondent practiced medicine with gross negligence, abandoned a patient and failed to maintain accurate records.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License for three years and to stay the suspension in part.
3. The ARB modifies the Committee's Determination to stay the suspension for all but six months.
4. The ARB overturns the Committee's Determination to limit the Respondent's License for two and one-half years.
5. The ARB votes to limit the Respondent's License permanently to practice in a general hospital only.

Robert M. Briber
Thea Graves Pellman
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Joel Novendstern, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Novendstern.

Dated: November 5, 2003



Robert M. Briber

In the Matter of Joel Novendstern, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Novendstern.

Dated: Nov. 14, **2003**

Thea Graves Pellman

In the Matter of Joel Novendstern, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Novendstern.

Dated: November 7, **2003**

Stanley L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Joel Novendstern, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Novendstern.

Dated: November 5, 2003

Therese G. Lynch M.D.

Therese G. Lynch, M.D.