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

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IN THE MATTER OF STEVEN BRIGHAM, M.D.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

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TO: STEVEN BRIGHAM, M.D.
1 Alpha Avenue, Apt. 27
Voorhees, N.J. 08043

2 Pearlman Drive
Spring Valley, N.Y.

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by STEVEN BRIGHAM, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately STEVEN BRIGHAM, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless

modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 14th day of January, 1994 at 10:00 a.m. at 5 Penn Plaza, 6th Fl., New York, N.Y., 10001 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the

State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
January 3, 1994

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
Marcia E. Kaplan
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza, 6th Fl.
New York, N.Y. 10001

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

IN THE MATTER OF STEVEN BRIGHAM, M.D.	STATEMENT OF CHARGES

STEVEN BRIGHAM, M.D., the Respondent, was authorized to practice medicine in New York State on September 24, 1987 by the issuance of license number 172457 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 1 Alpha Avenue, Apt. 27, Voorhees, N.J. 08043.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 20 year old female, at the American Medical Pavilion and AB Services of New York, 2 Pearlman Drive, Spring Valley, N.Y. (hereafter "office") from on or about November 10, 1993 through on or about November 11, 1993. (The identity of Patient A, and all other patients, is disclosed in the attached Appendix.) On or about November 10, 1993, at or after 5 p.m., Respondent performed an ultrasound on Patient A and told her that her pregnancy was

26 weeks. Patient A's LMP was May 14, 1993. Respondent placed 12 laminaria and injected 6cc digoxin into the fetal heart in preparation for a termination of pregnancy procedure. Patient A was instructed to return the next morning at 9 a.m.

On or about November 11, 1993, at or about 9 a.m., Patient A returned to the office. Respondent performed a D&E procedure to terminate Patient A's pregnancy. At or about 11 a.m., Patient A was transferred into the recovery room, where she remained for approximately one hour. While in the recovery room, Patient A bled profusely, vomited and lost consciousness. From at or about noon until at or about 3:00 p.m., she was treated by Respondent at the office. At 2:55 p.m., Patient A's hematocrit was 18%. Respondent thereafter transferred Patient A by ambulance to Nyack Hospital. Patient A was in shock on arrival at the hospital. The cervical laceration extended up into the lower uterine segment; the uterine artery had been lacerated. An emergency hysterectomy was performed.

1. Respondent failed to counsel Patient A appropriately prior to the D&E procedure, or to note such counseling.

2. Respondent failed to prepare Patient A's cervix adequately prior to starting the evacuation procedure.

3. Respondent continued to perform a D&E procedure on Patient A, which was inappropriate under the circumstances.

4. Respondent failed to have appropriate transfer arrangements in place prior to starting the D&E procedure on Patient A.

5. Respondent failed to recognize the existence of the laceration at or before the end of the D&E procedure.

6. Respondent failed to recognize the gravity of the laceration in a timely manner.

7. Respondent continued to attempt to repair the laceration in the office after Patient A's condition required her transfer to a hospital.

8. From at or about 2:35 p.m. until he received the hematocrit results at or about 2:55 p.m., Respondent failed to recognize that Patient A was in shock.

9. Respondent delayed inappropriately in transferring Patient A to a hospital.

B. Respondent treated Patient B at Flushing Gynecology Center, (aka Flushing Women's Center; hereafter "Center") 36-09 Main Street, Flushing, New York 11354, from on or about May 7, 1992 through on or about May 9, 1992. On or about May 7, 1992, Respondent noted that by ultrasound the pregnancy was 23.5 weeks. The fetus had multiple anomalies. On or about May 8, 1992, Respondent placed 6 laminaria of unrecorded size in preparation for a termination of pregnancy procedure. On or about May 8, 1993, Respondent began a D&E procedure to terminate Patient B's pregnancy at the center. Hern forceps were used to remove an arm and part of the placenta when omentum was seen. Patient B was transferred by ambulance to Elmhurst Hospital Center, 79-01 Broadway, Elmhurst, N.Y.

11373. At laparotomy, there was an 8-10 cm. laceration of the posterior uterus. The sigmoid colon and mesentery were injured. Patient B required a colostomy. Both ureters were damaged: the right ureter had a partial laceration and the left ureter had a complete transection. Transfusion of 4 units of packed cells was done.

1. Respondent failed to prepare Patient B's cervix adequately prior to starting the evacuation procedure.

2. Respondent continued to perform a D&E procedure in the face of an inadequately dilated cervix, which was inappropriate under the circumstances.

3. Respondent performed the D&E procedure inappropriately, causing injury to Patient B's uterus, bowel and ureters.

C. Respondent treated Patient C, a 94 year old female, at her sister's home at 320 E. 42nd St., New York, N.Y. 10017 from on or about November 1, 1988 through on or about November 19, 1988.

1. Respondent failed to perform an appropriate social history in that he failed to ascertain or to note whether Patient C had any living next of kin other than Patient D, or any other relatives or support systems.

2. Respondent failed to order or perform appropriate blood tests.

3. Respondent prescribed Dilaudid inappropriately.

4. Respondent administered B12 30 micrograms IM inappropriately.

5. Respondent failed to evaluate Patient C's diarrhea appropriately on or about November 17, 1988.

6. Respondent failed to transfer Patient C to a hospital, as required by her condition, on or after November 17, 1993.

D. Respondent treated Patient D, a 91 year old female, at her home at 320 E. 42nd St, New York, N.Y. 10017 from on or about November 1, 1988 through November 20, 1988.

1. Respondent failed to perform an appropriate social history in that he failed to ascertain or to note whether Patient D had any living next of kin other than Patient C, or any other relatives or support systems.

2. Respondent failed to perform or note an adequate evaluation of Patient D's chief complaint of "a sore on the foot."

3. Respondent prescribed and/or administered morphine and/or penicillin IM for Patient D inappropriately.

4. On or about November 17, 1988, Respondent made and noted a possible diagnosis of "mitral stenosis/regurgitation" which was not substantiated by his findings, as noted.

E. Respondent treated Patient E, a 36 year old male, at the Smoke Stop Program, 905 Fifth Avenue, New York, N.Y. 10021 on or about June 20, 1988.

1. Respondent diagnosed chronic bronchitis, which was not supported by the findings.

2. Respondent failed to follow-up Patient E's blood pressure reading of 140/90 and/or failed to refer Patient E for such follow-up.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform.

F. Respondent treated Patient F, a 31 year old male, at the Smoke Stop Program, 205 East 64th Street, Suite 203, New York, N.Y. 10021, on or about October 10, 1989.

1. Respondent failed to perform or note an adequate history.

2. Respondent failed to perform or note an adequate physical examination.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient F.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform.

G. Respondent treated Patient G, a 32 year old female, at the Smoke Stop Program, 205 East 64th Street, Suite 203, New York, N.Y. 10021 on or about February 2, 1989.

1. Respondent made a diagnosis of COPD which was not supported by the findings.

2. Respondent ordered or performed an inadequate electrocardiogram and/or failed to recognize that the electrocardiogram was inadequate and have it repeated.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient G.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform and/or for an electrocardiogram which he knew was inadequately performed and/or reported a diagnosis of COPD which he knew was not supported by the findings.

H. Respondent treated Patient H, a 45 year old male, at the Smoke Stop Program, 905 Fifth Avenue, New York, N.Y. 10021 from on or about February 14, 1989 through February 22, 1989.

1. Respondent made a diagnosis of chronic bronchitis which was not supported by the findings.

2. Respondent ordered or performed an electrocardiogram without appropriate medical indication.

3. Respondent ordered or performed an electrocardiogram which was technically inadequate and/or failed to recognize that the electrocardiogram was technically inadequate and have it repeated.

4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient H.

5. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform and/or reported a diagnosis of chronic bronchitis which he knew was not supported by the findings.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower   The Governor Nelson A. Rockefeller Empire State Plaza   Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner
Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

April 29, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Marcia Kaplan, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Steven Brigham,Esq.
1 Alpha Avenue
Voorhees, NJ 08043

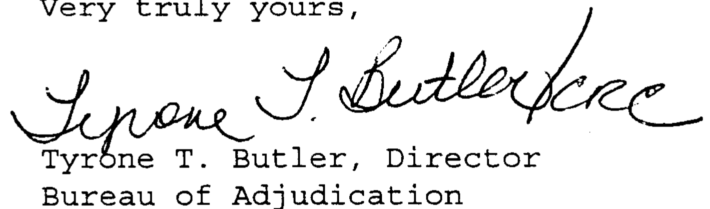
Nathan L. Dembin, Esq.
225 Broadway, Suite 1905
New York, New York 10007

RE: In the Matter of Steven Brigham, M.D.

Dear Ms. Kaplan, Mr. Dembin and Dr. Brigham:

Enclosed please find the Interim Order signed by the Commissioner in the above referenced matter.

Very truly yours,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc

Enclosure

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

IN THE MATTER OF STEVEN BRIGHAM, M.D. RESPONDENT	INTERIM ORDER OF THE COMMISSIONER

This matter was commenced by a Summary Order dated January 3, 1994. A hearing was held (after an adjournment at the request of Respondent) on February 3, March 2, 9, 10, 18, 23 and April 5, 6, 13, 14, and 21, 1994 before **ANN SHAMBERGER, Chairperson, WILLIAM P. DILLON, M.D., and LEMUEL A. ROGERS, M.D.**, duly designated members of the State Board for Professional Medical Conduct, who served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JONATHAN M. BRANDES, ESQ.**, Administrative Law Judge, served as the Administrative Officer.

The State Board For Professional Medical Conduct appeared by **Marcia E. Kaplan, Esq.**, Associate Counsel, of counsel to **PETER J. MILLOCK**, General Counsel. Respondent appeared by Nathan L. Dembin & Associates, **NATHAN L. DEMBIN, Esq.**, of counsel. Evidence was received and witnesses sworn and heard. A transcript of this proceeding was made.

After consideration of the entire record, the Hearing Committee issued their determination with regard to imminent danger, on the record. A copy of the relevant transcript pages containing that determination is attached hereto and made a part hereof.

Now, upon consideration of the entire record and the determination of the Hearing Committee in this matter, it is hereby **ORDERED:**

That the Summary Order in this matter dated January 3, 1994, shall remain in full force and effect.

Dated :
Albany, New York,
April 29, **1994**

Mark R. Chassin, M.D., M.P.P., M.P.H.