FILED

NOVEMBER 7, 2007

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

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| In the Matter of: | * | |
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| DEREK Q. CHAPMAN, M.D. | * | CONSENT ORDER |
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This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of a report from the Medical Practitioner Review Panel (the "Panel") setting forth findings made at the conclusion of the Panel's investigation of notice detailing that a payment of $275,000 was made to settle a medical malpractice action brought against respondent Derek Q. Chapman, M.D. The malpractice action was predicated upon allegations that respondent negligently failed to diagnose an ectopic pregnancy, which in turn was alleged to have caused the death of a 20 year old patient, R.P., who expired after the ectopic pregnancy ruptured.

During the course of its investigation, the Panel considered information and records developed during the malpractice action, to include, without limitation, R.P.'s hospital records. The Panel additionally considered testimony offered by respondent when he appeared before the Panel, represented by Jeffrey N. German, Esq., on June 15, 2007.

Upon review of available information, the Panel found that R.P. presented to the emergency room (at a hospital where respondent was "moonlighting" as a house officer for obstetrics and gynecology) on November 13, 2000, with complaints of abdominal cramps and vomiting. R.P. was then hypotensive with lower abdominal pain and a positive pregnancy test, and was status post an elective abortion in September 2000. Respondent was called to evaluate R.P., and was then informed that R.P. had a possible ectopic pregnancy. Respondent took a history and performed a pelvic and abdominal examination of the patient while she was in the ultrasound department (where an ultrasound was performed). Respondent did not obtain R.P.'s vital signs when he examined R.P. (to include the patient's pulse and/or blood pressure) and failed to adequately review R.P.'s medical record (and thereby obtain significant information that had been recorded on evaluations that had been performed in the emergency room, to include information regarding low blood pressure readings and a positive tilt test).

Respondent observed the ultrasound images, and saw what he then believed to be an empty gestational sac. Respondent reported his observations to an attending physician, but did not follow-up and obtain the official report of the radiologist (which stated that an ectopic pregnancy "was certainly a possibility"). Respondent made a differential diagnosis of early pregnancy, blighted ovum or a missed abortion, and R.P. was thereafter

discharged. R.P. returned to another hospital 10 hours later in cardiac arrest and hemorrhagic shock secondary to a ruptured right ectopic pregnancy with hemoperitoneum. She could not be stabilized and expired.

The Panel concluded that respondent was grossly negligent in his provision of care to R.P. In particular, the Panel found that respondent's failure to obtain vital signs when he examined R.P. and his failure to adequately review R.P.'s medical record (and thereby obtain significant information that had been recorded on evaluations that had been performed in the emergency room) constituted gross negligence. The Panel also concluded that respondent engaged in further negligence by failing to have consulted with the radiologist to confirm his interpretation of the ultrasound (before reporting to the attending physician and before implementing the plan to discharge R.P. from the emergency room), and generally by failing to have adequately considered R.P.'s past medical history in detail before she was discharged.

The Board has reviewed the Panel's report and adopted all findings and recommendations made by the Panel, to include the Panel's finding that respondent engaged in gross negligence in this case. Based thereon, the Board concludes that basis for disciplinary action against respondent exists pursuant to N.J.S.A. 45:1-21(c) and/or 45:1-21(d).

The parties desiring to resolve this matter without need for formal disciplinary proceedings, and the Board being satisfied

that the need for such proceedings is obviated by the entry of the within Order, and being further satisfied that good cause exists to support entry of the within Order,

IT IS on this 26th day of September, 2007,

ORDERED AND AGREED:

1. Respondent Derek Chapman, M.D. is hereby reprimanded for having engaged in gross negligence in connection with his provision of care to patient R.P., as detailed above.

2. Respondent is assessed a civil penalty in the amount of $5,000, which penalty shall be payable in full upon entry of this Order.

NEW JERSEY STATE
BOARD OF MEDICAL EXAMINERS

Mario A. Criscito, M.D.

By: _____
Mario A. Criscito, M.D.
Board President

I consent to the entry of this Order by the State Board of Medical Examiners.

Derek Q. Chapman, M.D.

Derek Q. Chapman, M.D.

## NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

(1) Which revokes or suspends (or otherwise restricts) a license,
(2) Which censures, reprimands or places on probation,
(3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license(and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A.45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.