IN THE MATTER OF	*	BEFORE THE MARYLAND
DEBORAH ROPISKI, RCP	*	STATE BOARD OF
Respondent.	*	PHYSICIANS
License No. L00718	*	Case No.: 2009-0805

* * * * * * * * * * * *

FINAL DECISION AND ORDER

INVESTIGATIVE AND PROCEDURAL HISTORY

Deborah Ropiski, License No. L00718, is a respiratory care practitioner ("RCP") licensed with the Maryland State Board of Physicians ("Board") since 1992.

1. Board Investigation

In April, 2009, the Board began an investigation after receiving a report from three staff members at a Maryland hospital stating that Ms. Ropiski was removed from her position due to concerns about patient safety. Ms. Ropiski has a degenerative disease, Usher's Syndrome,[1] which affects her hearing and vision. In May, 2009, Ms. Ropiski sent an unsolicited letter to the Board stating that she was "inappropriately removed" from her position. The Board sent a written notice to Ms. Ropiski in June, 2009, advising her of the Board's investigation and requesting a written response. In her response, Ms. Ropiski denied that her medical condition had deteriorated and questioned the validity of the Fitness for Duty Exam performed in January, 2009, at the request of her employer.

In January, 2010, the Board ordered that Ms. Ropiski be evaluated by a Board-approved ophthalmologist with clinical experience treating Usher's Syndrome. The examining ophthalmologist diagnosed Ms. Ropiski with "profound bilateral retinopathy." The Board also

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[1] Usher's Syndrome is a condition characterized by hearing loss or deafness and progressive vision loss. The loss of vision is caused by an eye disease called retinitis pigmentosa ("RP"), which affects the retina, the layer of light sensitive tissue at the back of the eye.

referred the case to a Board-approved RCP for an opinion on whether Ms. Ropiski's visual and hearing impairments prevented her from performing her job duties. In April, 2010, the Board's expert submitted a report indicating that in his professional opinion, Ms. Ropiski was physically incompetent to practice respiratory therapy.

Details of the Board's investigation showed the following:

Hospital Personnel File

1. Ms. Ropiski's personnel file from her hospital employer revealed that she was directed to participate in a Fitness for Duty Examination, in January, 2009, following numerous complaints from patients and staff members that she was having difficulty hearing and responding to patients and staff as a result of hearing and visual impairments.

2. In 2008, an internal memo from the Director of the hospital's respiratory care department stated that during a discussion with Ms. Ropiski about her communication difficulties, Ms. Ropiski admitted that she had already removed herself from the Intensive Care Unit ("ICU") because of her concern with her ability to function in the ICU. Ms. Ropiski also stated that she was having problems with her peripheral vision.

3. In January, 2009, an internal e-mail from a Lab Coordinator/Clinical Specialist to the Director of the Respiratory Care Department reported difficulties that Ms. Ropiski was having communicating with patients. The e-mail stated that "patients are having some difficulties communicating secondary to [Ms. Ropiski's] hearing [loss]." The e-mail also mentioned that on "many occasions patients ask questions . . . that [Ms. Ropiski] is not aware of " and concluded "I am concerned that she is unable to hear when a patient is in distress or pick up on information that may be necessary."

4. Another e-mail in January, 2009 recorded an incident where a patient's pulse oximeter[2] decreased from 97% to 83% within a few minutes because Ms. Ropiski could not hear the leaking oxygen tank hissing. The staff member also reported that she observed Ms. Ropiski mishearing the patient's statements on multiple occasions.

5. Ms. Ropiski's Fitness for Duty Examination revealed that she used both a cochlear implant[3] and a digital hearing aid, which enabled her to hear general sounds in the 30-40 db HL (Hearing Loss) range, but that this would make it difficult for her to hear normal breath sounds (10-20db HL) or arterial blood pressure through a stethoscope.

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[2] Pulse oximetry is a non-invasive method of monitoring the concentration of oxygen in the blood. The pulse oximeter consists of a probe attached to the patient's finger or ear lobe which is linked to a computerized unit that displays the percentage of oxygen saturation in the blood with an audible signal for each pulse beat. An oximeter detects hypoxia before the patient becomes clinically cyanotic.

[3] A cochlear implant is a surgically implanted electronic hearing device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing.

6. The examiner documented his concern that Ms. Ropiski's "loss of peripheral vision, combined with her hearing loss, seriously diminished her chances of recognizing or responding to an emergency out of her direct line of sight . . ." and "greatly increases the risk of patient accidents and possible fatalities." The Examiner recommended that Ms. Ropiski work in a "controlled environment with as much direct supervision as possible, to avoid any undue risk to patients."

7. On February 12, 2009, Ms. Ropiski received an e-mail from the hospital's Human Resources department stating that:

   > Due to the safety concerns expressed and relative to your inability to perform the essential functions of your role as RCP, you have been removed from this position.

8. On February 18, 2009, Ms. Ropiski sent a letter to the hospital requesting accommodations under the Americans with Disabilities Act ("ADA").

9. On February 25, 2009, an internal e-mail from the Medical Director of Respiratory Therapy to the Director of the Respiratory Care Department documented that although Ms. Ropiski exhibited great professionalism and competency, her inability to hear patients and medical staff "frequently leads to miscommunication."

10. On March 27, 2009, the hospital's Human Resources department responded to Ms. Ropiski's request for accommodation by agreeing to allow a representative from the Maryland Department of Rehabilitative Services ("DORS") to conduct an on-site assessment. Ms. Ropiski was placed on paid leave until the assessment was completed.

11. On April 9, 2009, Ms. Ropiski was examined by a licensed audiologist on behalf of DORS. DORS completed its report which noted that even with the use of the cochlear implant, Ms. Ropiski had a slight to mild hearing loss bilaterally, and that "[s]peech discrimination ability, for conversational level speech, is fair to poor monaurally and fair bilaterally."

12. The report noted that Ms. Ropiski reported that her vision was restricted in all four dimensions and she could not see below chest level without moving her head. The examiner noted that Ms. Ropiski's vision impairment "seems to be impacting her interaction more than she may realize." Ms. Ropiski self-reported to the examining audiologist that she could not hear oxygen escaping from tubing.

13. DORS provided recommendations regarding assistive technology that might aid Ms. Ropiski in improving her auditory comprehension. In an internal memorandum dated July 21, 2009, the hospital's management stated that it would not implement the accommodations suggested by DORS because it did not believe that the accommodations would enable Ms. Ropiski to fulfill the essential job duties of her position.

14. On August 4, 2009, the hospital made a decision to remove MS. Ropiski from her role as a respiratory therapist effective August 7, 2009.

Medical Records

15. In August, 2009, the Board requested Ms. Ropiski's medical records from her treating ophthalmologist. The records revealed that she was evaluated for Usher's Syndrome in March, 2008, because of her complaints of degenerating night vision as well as cloudy vision in her left eye. This resulted in her "running into things . . . more frequently." In March, 2009, Ms. Ropiski underwent an eye examination and complained of cloudy vision in her left eye and worsening cataracts.

16. Medical records received from the hospital where Ms. Ropiski was being followed for a cochlear implant revealed that she was given a cochlear implant activated on May 4, 2001. Thereafter, she was regularly seen for follow up to check the status of her implant. In November, 2007, Ms. Ropiski reported that her vision was worsening. In June, 2008, she reported that she heard constant noise in quiet environments which interfered with her work. No defect with the implant devise was detected. In March, 2009, Ms. Ropiski indicated that she was having difficulty at work because of her hearing problems.

17. In August, 2009, the Board requested records from a private audiology practice located in Bel Air, Maryland, which provided care to Ms. Ropiski. In January, 2009, the audiologist noted that "With the use of a hearing aid and cochlear implant, the findings were consistent with mild hearing loss." At this level, Ms. Ropiski had the ability to hear general sounds in the 30-40 db HL range.

18. The Board also requested medical records from the private medical practice that completed Ms. Ropiski's Fitness for Duty Examination requested by her employer hospital. The examiner's findings indicated that her impaired vision and hearing loss interfered with her ability to respond to patient emergencies.

19. In January, 2010, Ms. Ropiski attended a Board ordered examination with a board-certified ophthalmologist with clinical experience treating Usher's Syndrome. The ophthalmologist reported that:

> . . . [T]he patient's visual field shows marked constriction in both eyes and all isopters, with the most noticeable binocular reductions in the upper and lower fields (30-40 degrees above and below the meridian for large obstacles in daylight). The binocular horizontal field diameter for the lll-4e target is 44 degrees . . . [T]he full field ERG responses are consistent with profound bilateral retinopathy, in which both rod and cone response are compromised.

20. In April, 2010, the Board RCP expert submitted a written report indicating in his professional opinion that Ms. Ropiski was physically incompetent to practice respiratory therapy. The expert opined that a respiratory care practitioner's high reliance on audio-

visual acuity meant that Ms. Ropiski could no longer safely perform essential functions of her job. He noted that her poor vision and hearing limits her ability to properly perform and read pulmonary function related testing, threatening patient safety, e.g., he noted that she might have difficulty reading blood gas test results or monitoring patients' respiratory efforts.

21. He further expressed concern that Ms. Ropiski's 'occasional unexpected blurred vision' represented a "huge patient safety. . . concern" and increased the risk of having a "sentinel safety event" causing harm to patients or hospital staff. In summary, the expert concluded that he was "strong[ly] concerned" about the risk that Ms. Ropiski's physical condition posed for patient safety and recommended restricting her license to practice respiratory therapy.

2. <u>Administrative Proceedings</u>

On September 21, 2011, the Board charged Ms. Ropiski with physical incompetence to practice respiratory therapy, in violation of H.O. § 14-5A-17(a)(4), and sent a copy of the charges to her address of record[4] at 708 MacPhail Court, North, Bel Air, Maryland 21014.

Pursuant to the contested case provisions of the Administrative Procedure Act ("APA"), a formal hearing procedure was commenced before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings ("OAH"). Md. Code Ann., State Gov't § 10-205; *see also* H.O. §14-405 (requiring the Board to give an opportunity for a hearing under the APA). On May 17, 2012, the OAH sent notice to the parties that a Prehearing Conference would be held at the OAH on June 20, 2012 at 9:30 a.m., and also sent notice that an evidentiary hearing would be held at the OAH on July 31, August 1 and 2, 2012, to commence at 9:30 a.m.

The Prehearing Conference Notice advised Ms. Ropiski that her failure to appear or give timely notice of her inability to appear for the in-person Prehearing Conference might result in a decision against her. The Prehearing Conference instructions also required that each party file a Prehearing Statement with the OAH and the Office of the Attorney General no later than 15 days

4 Pursuant to the Medical Practice Act, each licensee is required to "notify the secretary of the Board in writing of any change in the licensee's name or address within 60 days after the change." H.O. § 14-316(f)(1). Ms. Ropiski did not notify the Board of any changes in her name or address.

before the scheduled June 20, 2012 Prehearing Conference. Ms. Ropiski did not file a Prehearing Conference Statement.

As required by statute, the notice of Charges, Prehearing Conference and Hearing were mailed to Ms. Ropiski's address of record with the Board. Ms. Ropiski failed to appear either in person or through counsel at the June 20, 2012 Prehearing Conference at the OAH. The Administrative Prosecutor appeared on behalf of the State, made a Motion for Default against Ms. Ropiski, and requested that the Board's charges be upheld and Ms. Ropiski's license be revoked.

On June 26, 2012, the ALJ issued a Proposed Default Order (incorporated into this Final Decision and Order and appended as Attachment A) proposing that: (1) Ms. Ropiski be found in default; (2) the Board's charges of physical incompetence to practice respiratory therapy against Ms. Ropiski be upheld; (3) the Board revoke Ms. Ropiski's license to practice respiratory care; (4) all further proceedings be terminated; and (5) Ms. Ropiski may file written exceptions to the Proposed Default Order within 15 days.

Neither Ms. Ropiski nor the Administrative Prosecutor filed exceptions, and the case came before the Board for final disposition. After considering the entire record, the Board issues this Final Decision and Order as the Board's final disposition in this case.

FINDINGS OF FACT

The Board adopts as findings of fact all of the Allegations of Fact, numbered 1-30, in the Board's September 21, 2011 charging document issued in this case. (The Board's charging document dated September 21, 2011 is incorporated into this Final Decision and Order and appended as Attachment B). The Board finds that these factual allegations and charges are unrefuted due to Ms. Ropiski's default. The Board also adopts as factual findings the ALJ's

Findings of Fact and Discussion of Ms. Ropiski's failure to respond to the Board's charges and her failure to appear at the OAH as set forth on pages 1-3 of the ALJ's Proposed Default Order.[5] Ms. Ropiski was duly notified of the Board's charges, of the prehearing conference, and of the evidentiary hearing, but she failed to respond or to appear in person or through counsel at any of the conferences scheduled in her case. The Board also adopts the ALJ's proposed decision to proceed to a revocation of Ms. Ropiski's respiratory care practitioner license on the basis of her default.

CONCLUSIONS OF LAW

The Board concludes that Ms. Ropiski was physically incompetent, in violation of H.O. § 14-5A-17(a)(4). Further, the Board concludes that Ms.Ropiski was in default with respect to answering the charges, thus she has lost the right to contest them.

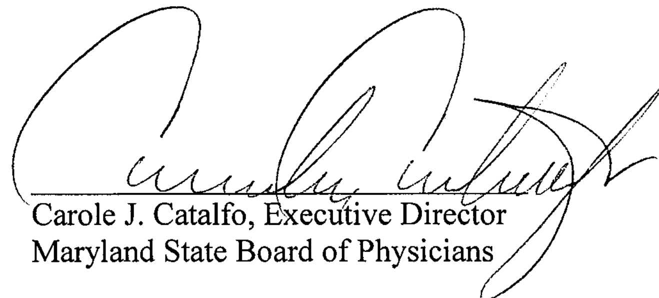
ORDER

It is hereby **ORDERED** that the Board's September 21, 2011 charges filed against Deborah Ropiski, License No. L00718, be **UPHELD**; and it is further

ORDERED that the license of Deborah Ropiski, License No. L00718, to practice respiratory care in the State of Maryland be **REVOKED**; and it is further

ORDERED that this is a Final Decision and Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't § 10-611 *et seq.* (Repl. Vol. 2009).

10-17-12
Date



Carole J. Catalfo, Executive Director
Maryland State Board of Physicians

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[5] Pursuant to the Administrative Procedure Act, the Board modifies the ALJ's Proposed Default Order on page 2, ¶ 1, to reflect that the Board notified Ms. Ropiski that she was under investigation on June 2, 2011. *See* Md. Code Ann., State Gov't § 10-216(b).

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-5A-17.1, Ms. Ropiski has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Ms. Ropiski files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Deputy Director, Compliance and Licensure
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

Noreen M. Rubin
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

IN THE MATTER OF THE STATE	*	BEFORE JEROME WOODS, II,
BOARD OF PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
DEBORAH ROPISKI, R.C.P.	*	OF ADMINISTRATIVE HEARINGS
License No. L00718	*	OAH No.: DHMH-SBP-78-12-19953

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PROPOSED DEFAULT ORDER

STATEMENT OF THE CASE
FINDINGS OF FACT
DISCUSSION
PROPOSED ORDER

STATEMENT OF THE CASE

On June 20, 2012, I convened a Prehearing Conference in the above-referenced matter at 9:30 a.m. at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, MD (the OAH). Debra A. Smith, Assistant Attorney General, Administrative Prosecutor, appeared on behalf of the State of Maryland, State Board of Physicians (Board). The Prehearing Conference was scheduled to begin at 9:30 a.m.; as of 10:00 a.m., Deborah Ropiski (Respondent), Respiratory Care Practitioner (RCP), license number L00718, did not appeared for the conference.[1] Upon the Respondent's failure to appear, the State moved for a Proposed Default Order, citing several documents in the administrative record and the Board's Exhibit Notebook, accepted into evidence as Board Exhibit Number 1.

FINDINGS OF FACT

In consideration of the State's Motion for Proposed Default, I find the following:

[1] On June 13, 2012, the Respondent sent correspondence and a copy of the Notice for the Prehearing Conference to the OAH and to the Board indicating that she would not be participating in the proceedings and that her respiratory care practitioner license lapsed on May 31, 2012.

ATTACHMENT A

1. By letter dated September 21, 2011 the Board notified the Respondent that she was under investigation after receiving a report from a hospital that the Respondent was removed from her role as an RCP and a Certified Pulmonary Function Technologist due to concern for patient safety. The Board sent the letter to the Respondent's address of record with the Board: 708 MacPhail Court North, Bel Air, Maryland, 21014.
2. On September 21, 2011, the Board charged the Respondent under the Maryland Respiratory Care Practitioners Act (Charges).
3. On May 17, 2012 the OAH sent notice to the parties stating that a Prehearing Conference would be held at the OAH on June 20, 2012, at 9:30 a.m., and an evidentiary hearing to be held at OAH on July 31, August 1 and August 2, 2012, to commence at 9:30 a.m.
4. The Prehearing Conference instructions required that a Prehearing Statement be filed with the OAH and the Office of the Attorney General no later than fifteen days before the June 20, 2012 Prehearing Conference. The Respondent did not file a Prehearing Conference Statement.
5. The Prehearing Conference Notice advised the Respondent that "failure to appear or to give timely notice of your inability to appear for the prehearing conference may result in a decision against you."

DISCUSSION

Section 14-405(b) of the Maryland Medical Practice Act (Md. Code Ann., Health Occ. §§ 14-401 through 14-702 (2009 & Supp. 2011) requires that notice of a hearing be given to a respondent in accordance with the Title 10, Subtitle 2 of the State Government Article, the

contested case provisions of Maryland's Administrative Procedure Act (APA). Those notice requirements were met in this case. *See*, Md. Code Ann., State Gov't. § 10-209 (2009). *See also,* Md. Code Ann., Health Occ. § 14-316(f)(1) ("Each licensee shall notify the secretary of the Board in writing of any change in the licensee's name or address within 60 days after the change.") When notice has been provided in the manner required by statute or regulation, the party to whom the notice has been directed has no legitimate claim that the notice given was inadequate or defective. *See State v. Barnes*, 273 Md. 195 (1974).

The notice of Charges, Prehearing Conference and hearing were mailed to the Respondent as required by statute. The notices were sent to the Respondent's address of record with the Board. The Respondent failed to appear after proper notice and is subject to default. Code of Maryland Regulations (COMAR) 28.02.01.20A.

In its motion for default, the State requested that the Board's Charges be upheld and that the Respondent's license be revoked. By this order I propose that the Board's requests be granted.

PROPOSED ORDER

IT IS, THEREFORE, PROPOSED that the Respondent, Deborah Ropiski, be found in default; and

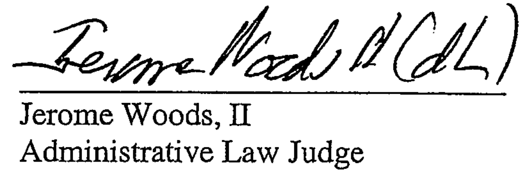
IT IS FURTHER PROPOSED that the Charges asserting that the Respondent's physical condition as outlined in the Charges, constitutes physical incompetence to practice respiratory therapy, in violation of the Medical Malpractice Act, Md. Code Ann., § 14-5A-17(A)(4) be upheld; and

IT IS FURTHER PROPOSED that the Respondent's license to practice respiratory care be revoked; and

IT IS FURTHER PROPOSED that all further proceedings in the above-captioned matter be **TERMINATED;** and

FURTHER, in accordance with COMAR 28.02.01.23C and COMAR 10.32.02.03F, the Respondent or her authorized representative may file exceptions to this Proposed Order with the Board within fifteen days.

June 26, 2012
Date Proposed Order Mailed



Jerome Woods, II
Administrative Law Judge

JW/rbs
#135688

Copies Mailed To:

Deborah Ropiski, RCP
708 Mac Phail Court, North
Bel Air, MD 21014

Debra Smith
Assistant Attorney General
Office of the Attorney General
300 W. Preston Street, Suite 207
Baltimore, MD 21201

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4201 Patterson Avenue
Baltimore, MD 21215

Rosalind Spellman, Administrative Officer
Health Occupations Prosecution and Litigation Division
Office of the Attorney General
300 W. Preston Street, Room 201
Baltimore, MD 21201

Paul T. Elder, M.D., Chairman
State Board of Physicians
Metro Executive Plaza
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John Nugent, Principal Counsel
Health Occupations Prosecution and Litigation Division
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300 W. Preston Street, Room 201
Baltimore, MD 21201

IN THE MATTER OF THE STATE	*	**BEFORE JEROME WOODS, II,**
BOARD OF PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
DEBORAH ROPISKI, R.C.P.	*	**OF ADMINISTRATIVE HEARINGS**
License No. L00718	*	**OAH No.: DHMH-SBP-78-12-19953**

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FILE EXHIBIT LIST

At the State's request, the following documents are incorporated into the record:

1. Letter from the Board to the Respondent, dated September 21, 2011 with attachments
2. Complaint Form, dated April 30, 2009 with attachments
3. Report of Investigation, dated June 23, 2010 with attachments
4. Letter from the Respondent to the Board, dated May 13, 2009
5. Letter from the Board to the Respondent, dated June 2, 2009
6. E-mail from the Respondent to the Board, dated June 18, 2009 with attachments
7. Information form, dated June 18, 2009 with attachments
8. Letter from John DiDomenico, Respiratory Care Manager to the Board, dated April 23, 2010 with attachments
9. Letter from the Board to the Respondent, dated July 29, 2009
10. Letter from the Board to Bruce Lewis, Urgent Care, dated August 4, 2009, with attachments
11. Letter from the Board to the Respondent, dated August 5, 2009
12. (No document behind tab 12)
13. Letter from the Board to Robert Lise, dated October 30, 2009
14. Letter from the Board to the Respondent, dated November 10, 2009
15. Letter from the Respondent to the Board, dated December 3, 2009
16. Letter from the Board to the Respondent, dated December 4, 2009
17. Letter from the Board to the Respondent, dated December 15, 2009
18. Letter from the Board to Daniel Finkelstein, M.D., dated December 16, 2009
19. Letter from the Board to Mr. DiDomenico, dated February 19, 2010
20. Invoice, dated February 27, 2009, with attachments
21. Letter from Maryland State Department of Education to the Respondent, dated August 13, 2009, with attachments
22. Letter from the Board to Jennifer Yeagle, dated August 4, 2009, with attachments
23. Letter from the Board to Patricia Dobyoski, dated August 4, 2009, with attachments
24. Letter from the Board to Dr, Polk (first name not given), dated August 4, 2009, with attachments

25. Letter from the Board to Carmen Anderson, dated August 25, 2009, with attachments
26. Johns Hopkins Medical Statement, dated January 7, 2010, with attachments
27. Memorandum from Jason Birnbaum, M.D. to Karen Goodison, dated June 6, 2007, with attachments

Deborah Ropiski R.C.P.	*	MARYLAND STATE BOARD OF
Respondent	*	PHYSICIANS
License Number: L00718	*	Case Number: 2009-0805

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CHARGES UNDER THE MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges Deborah Ropiski, R.C.P. (the "Respondent") (D.O.B. 9/13/58), License Number, L00718 under the Maryland Respiratory Care Practitioners Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 14-5A-01 *et seq.* (2009 Repl. Vol. & 2010 Supp.)

The pertinent provisions of the Act under § 14-5A-17(a) (4) provides the following:

§ 14-5A-17. Denials, reprimands, suspensions, and revocations- In general.

(a) *In general.* – Subject to the hearing provisions of §14-405 of this title, the Board on the affirmative vote of a majority of a quorum, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee:

(4) Is professionally, physically, or mentally incompetent;

GENERAL ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has reason

[1] The statements of the Respondent's conduct contained herein are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent.

ATTACHMENT B

to believe are true:

A. BACKGROUND

1. At all times relevant hereto, the Respondent was and is certified to practice respiratory therapy in the State of Maryland. The Respondent was initially certified as a respiratory care practitioner ("RCP") by the Board on April 23, 1992. The Respondent was certified by the National Board of Respiratory Care as a Registered Respiratory Therapist ("R.R.T.") on December 7, 1985 and a Certified Pulmonary Function Technologist ("C.P.F.T") on June 5, 1999.
2. At all relevant times hereto, the Respondent was employed at a hospital, hereinafter identified as Facility A.[2]
3. The Board initiated a disciplinary investigation after receiving a report on or about April 28, 2009, from three staff members at Facility A stating that the Respondent was removed from her role as a C.P.F.T. due to concern for patient safety. The Respondent has a degenerative disease, Usher's Syndrome,[3] which affects her hearing and vision.
4. On May 13, 2009 the Respondent sent an unsolicited letter to the Board responding to claims that she was no longer physically able to carry out the duties of an R.R.T. or C.P.F.T. The Respondent stated that she was

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[2] Facility A is not identified by name in this document to maintain the privacy of the facility, but the administrative prosecutor will provide this information to the Respondent upon request.

[3] Usher's syndrome is a condition characterized by hearing loss or deafness and progressive vision loss. The loss of vision is caused by an eye disease called retinitis pigmentosa (RP), which affects the retina, the layer of light sensitive tissue at the back of the eye.

"inappropriately removed" from her C.P.F.T. position, noting her "job evaluations [were] good" and she was under regular medical monitoring (every 6-12 months) for her hearing impairment.

5. On June 2, 2009, the Board sent the Respondent a written notice advising the Respondent of the Board's investigation and requesting a written response.

6. On June 18, 2009, the Board received a written response from the Respondent, denying that her medical condition had deteriorated and questioning the validity of the Fitness for Duty Exam performed on January 17, 2009 at the request of her employer. The Respondent also averred that although she had been informed of the fact that two complaints were made against her by patients at Facility A, no specifics were provided to her for review.

7. In or about January 2010, the Board ordered the Respondent evaluated by a Board approved ophthalmologist with clinical experience treating Usher's syndrome. The examining ophthalmologist in a report, dated January 27, 2010, diagnosed the Respondent with "profound bilateral retinopathy."

8. The Board also referred the case to a board approved RCP for an opinion regarding whether the Respondent's visual and hearing impairments prevented her from performing her job duties. In or about April 2010, the Board's expert submitted a written report indicating that in his professional

opinion the Respondent was physically incompetent to practice respiratory therapy.

B. FACILITY A'S RECORDS

9. As a part of its investigation, on June 3, 2009 the Board requested Respondent's personnel file from Facility A.

10. The Board's investigation revealed that in or about January 2009, Facility A directed the Respondent to participate in a Fitness for Duty Examination, after receiving numerous complaints from patients and other staff members that the Respondent was having difficulty hearing and responding to patients and staff as a result of hearing and visual impairments.

11. An internal memo dated January 7, 2008, from the Director of Facility A's Respiratory Care Department stated that during a discussion with the Respondent about her communication difficulties the Respondent admitted that she had already removed herself from the ICU (Intensive Care Unit) because of her concern with her ability to function in the ICU. The Respondent also stated that she was having problems with her peripheral vision.

12. On January 14, 2009, an internal e-mail from a Lab Coordinator/ Clinical Specialist to the Director of the Respiratory Care Department reported difficulties that the Respondent was having communicating with patients. The e-mail stated that "patients are having some difficulties communicating secondary to [the Respondent's] hearing [loss]."

Specifically, the e-mail mentions that on "many occasions patients ask questions... that [the Respondent] is not aware of." The e-mail concluded "I am concerned that she is unable to hear when a patient is in distress or pick up on information that may be necessary."

13. On January 16, 2009, an internal e-mail from another staff member to the Director of the Respiratory Care Department recorded an incident where a patient's pulse oximeter[4] decreased from 97% to 83% within a few minutes because the Respondent could not hear the leaking oxygen tank hissing. The staff member also reported that she observed the Respondent mishearing the patient's statements on multiple occasions.

14. On January 27, 2009, the Respondent underwent a Fitness for Duty Examination, by a certified physician's assistant at the request of her employer. The examiner noted that the Respondent used both a cochlear [5]implant and a digital hearing aid, which enabled her to hear general sounds in the 30-40 db HL (Hearing Loss) range, but that this would make it difficult for her to hear normal breath sounds (10-20 db HL) or arterial blood pressure through a stethoscope.

15. The examiner documented his concern that the Respondent's "loss of peripheral vision, combined with her hearing loss, seriously diminish her

[4] Pulse oximetry is a non-invasive method of monitoring the concentration of oxygen in the blood. The pulse oximeter consists of a probe attached to the patient's finger or ear lobe which is linked to a computerized unit. The unit displays the percentage of oxygen saturation in the blood with an audible signal for each pulse beat. An oximeter detects hypoxia before the patient becomes clinically cyanosed.

[5] A cochlear implant is a surgically implanted electronic hearing device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing.

chances of recognizing or responding to an emergency out of her direct line of sight...," and "greatly increases the risk of patient accidents and possible fatalities." The Examiner recommended that the Respondent work in a "controlled environment with as much direct supervision as possible, to avoid any undue risk to patients."

16. On February 12, 2009, the Respondent received an e-mail from Facility A's Human Resources department stating that:

> Due to the safety concerns expressed and relative to your inability to perform the essential functions of your role as R.C.P., you have been removed from this position.

17. On February 18, 2009, the Respondent sent a letter to Facility A requesting accommodations under the American's with Disabilities Act ("ADA").

18. On February 25, 2009, an internal e-mail from the Medical Director of Respiratory Therapy to the Director of the Respiratory Care Department documented that although Respondent exhibited great professionalism and competency, her inability to hear patients and medical staff "frequently leads to miscommunication."

19. On March 27, 2009, Facility A's Human Resources department responded to the Respondent's request for accommodations by agreeing to allow a representative from the Maryland Department of Rehabilitative Services (DORS) to conduct an on-site assessment. The Respondent was placed on paid leave until the assessment was completed.

20. On April 9, 2009, the Respondent was examined by a licensed audiologist on behalf of DORS. DORS completed a report which noted that even with the use of the cochlear implant the Respondent had a slight to mild hearing loss bilaterally, and that "[s]peech discrimination ability, for conversational level speech, is fair to poor monaurally and fair binaurally."

21. The report noted that the Respondent reported that her vision was restricted in all four dimensions and she could not see below chest level without moving her head. The examiner noted that the Respondent's vision impairment "seems to be impacting her interaction more than she may realize." The Respondent self-reported to the examining audiologist that she could not hear oxygen escaping from tubing.

22. At the conclusion of the assessment DORS provided recommendations regarding assistive technology that might aid the Respondent in improving her auditory comprehension. In an internal memorandum dated July 21, 2009, Facility A's management stated that it would not implement the accommodations suggested by DORS because it did not believe that the accommodations would enable the Respondent to fulfill the essential job duties of her position.

23. On or about August 4, 2009, Facility A made the decision to remove Respondent from her role as a respiratory therapist effective August 7, 2009.

C. RESPONDENT'S MEDICAL RECORDS

24. On or about August 4, 2009, the Board requested Respondent's medical records from her treating ophthalmologist. The records reveal that on or about March 27, 2008, the Respondent underwent an evaluation for Usher's Syndrome. The Respondent complained of degenerating night vision as well as cloudy vision in her left eye. This resulted in her "running into things ... more frequently." On March 27, 2009, the Respondent underwent an eye examination and complained of cloudy vision in her left eye and worsening cataracts.

25. On or about August 4, 2009, the Board requested medical records from the audiology department of a hospital, hereinafter "Facility B,"[6] where the Respondent was being followed for a cochlear implant. According to the medical records, the Respondent was given a cochlear implant which was activated on May 4, 2001. Thereafter, the Respondent was regularly seen for follow-up to check on the status of the implant. On November 13, 2007, the Respondent reported that her vision was worsening. On June 3, 2008, the Respondent reported that she heard constant noise in quiet environments which interfered with her work. No defect with the implant device was detected. On March 20, 2009, the Respondent indicated that she was having difficulty at work due to her hearing problems.

[6] Facility B is not identified by name in this document to maintain the privacy of the facility, but the administrative prosecutor will provide this information to the Respondent upon request.

26. On or about August 5, 2009, the Board requested records from a private audiology practice located in Bel Air, Maryland, which provided care to The Respondent. On January 28, 2009, the audiologist evaluating the Respondent noted that, "With the use of a hearing aid and cochlear implant, the findings were consistent with mild hearing loss." At this level, the Respondent had the ability to hear general sounds in the 30-40 db HL range.

27. On or about August 25, 2009, the Board requested medical records from the private medical practice that completed The Fitness for Duty Exam, requested by Facility A.[7] The examiner's findings indicated that the Respondent's impaired vision and hearing loss interfered with her ability to respond to patient emergencies.

28. On or about January 7, 2010, the Respondent attended a Board ordered evaluation with a board certified ophthalmologist with clinical experience treating Usher's syndrome. On January 27, 2010, the ophthalmologist reported that:

> ...[T]he patients visual field shows marked constriction in both eyes and all isopters, with the most noticeable binocular reductions in the upper and lower fields (30-40 degrees above and below the meridian for large obstacles in daylight). The binocular horizontal field diameter for the III-4e target is 44 degrees...[T]he full field ERG responses are consistent with profound bilateral retinopathy, in which both rod and cone mediated responses are compromised.

29. On or about April 23, 2010 the Board's RCP expert submitted a written report indicating in his professional opinion that the Respondent was

[7]The examiner's findings are discussed in detail in paragraphs 14 and 15 above.

physically incompetent to practice respiratory therapy. The expert opined that RCPs high reliance on audio-visual acuity meant that the Respondent could no longer safely perform essential functions of her job. He noted that the Respondent's poor vision and hearing limits her ability to properly perform and read pulmonary function related testing, threatening patient safety. For instance, the expert noted that the Respondent might have difficulty reading blood gas test results or monitoring patients' respiratory efforts.

30. He further expressed concern that the Respondent's 'occasional unexpected blurred vision' represented a "huge patient safety... concern" and increased the risk of having a "sentinel safety event" causing harm to patients or hospital staff. In summary, the expert concluded that he was "strong[ly] concern[ed]" about the risk the Respondent's physical condition posed patient safety and therefore recommended restricting the Respondent's license to practice respiratory therapy.

31. The Respondent's physical condition as outlined above constitutes physical incompetence to practice respiratory therapy in violation of H.O. § 14-5A-17(a) (4).

NOTICE OF POSSIBLE SANCTIONS

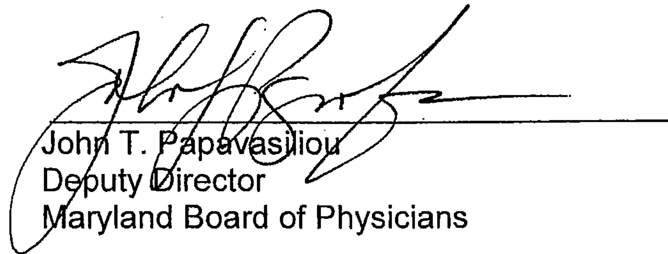
If, after a hearing, the Board finds that there are grounds for action under, H.O. § 14-5A-17(a) (4), the Board may impose disciplinary sanctions against the Respondent's license to practice respiratory therapy, including revocation, suspension, or reprimand, and the Board may place the Respondent on

probation. In addition, pursuant to H.O. § 14-5A-23, the Board may impose a monetary fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A case resolution conference in this matter has been scheduled for **November 2, 2011, at 10:00 a.m., at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215.**

9/21/2011
Date



John T. Papavasiliou
Deputy Director
Maryland Board of Physicians