IN THE MATTER OF	*	**BEFORE THE**
MANSUOR G. PANAH, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D15506	*	**Case Number: 2013-0854**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **MANSOUR G. PANAH, M.D.** (the "Respondent") (D.O.B., 02/8/1940), License Number D15506, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2009 Repl. Vol. and 2012 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the summary suspension. 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 in connection with this matter.

Licensing information

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on August 15, 1973, under License Number D15506. The Respondent's license is scheduled for renewal on September 30, 2013

2. The Respondent is board-certified in obstetrics and gynecology.

Prior disciplinary history

3. On June 30, 1988, the Respondent entered into a Consent Order with the Board (then known as the Commission on Medical Discipline) in which it found that he was guilty of immoral conduct in the practice of medicine, in violation of then Md. Health Occ. Code Ann. ("H.O.") § 14-504(3).[2] The Board found that the Respondent engaged in unwanted sexual contact with three patients. Pursuant to the Consent Order, the Board suspended the Respondent's medical license for 45 days.

4. On March 22, 1995, the Respondent entered into a Consent Order with the Board (then known as the Board of Physician Quality Assurance) in which it found that he was guilty of unprofessional conduct in the practice of medicine, in violation of then H.O. § 14-404(a)(3).[3] The Board found that the Respondent engaged in unwanted sexual contact with a patient. Pursuant to the Consent Order, the Board suspended the Respondent's medical license for 60 days, which it immediately stayed, and placed him on probation for three years, subject to a series of probationary terms and conditions.

[2] H.O. § 14-504(3) has since been recodified as H.O. § 14-404(a)(3)(i).

[3] H.O. § 14-404(a)(3) has since been recodified as H.O. § 14-404(a)(3)(ii).

5. On May 31, 2011, the Respondent entered into a Consent Order with the Board in which it found that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40). These cases pertained to the Respondent's performance of plastic and aesthetic procedures. Pursuant to the Consent Order, the Board reprimanded the Respondent and placed him on probation for two years, subject to a series of probationary terms and conditions.

Current complaints

6. At all times relevant hereto, the Respondent was the Medical Director of Associates in OB/GYN Care, LLC ("OB/GYN Care"), a practice that provides abortion services at offices located in Baltimore, Frederick, Cheverly and Silver Spring. In his capacity as Medical Director, the Respondent was responsible for the overall medical care that is provided by OB/GYN Care's surgical facilities. *See* Code Md. Regs. ("COMAR") tit. 10, § 12.01.05B.

7. The Board initiated an investigation of the Respondent after reviewing recent actions the Maryland Office of Health Care Quality ("OHCQ")[4] took against OB/GYN Care. OHCQ summarily suspended the licenses of three of OB/GYN Care's offices on or about March 5, 2013, and suspended the licenses of all four of its offices on May 9, 2013, for systemic violations of the State's surgical abortion facility regulations. *See* COMAR 10.12.01.01 *et seq.*

8. OHCQ determined that OB/GYN Care's continuing violations of the State's surgical abortion facility regulations placed patients at risk of serious harm or death.

[4] OHCQ licenses and certifies state health care facilities and monitors the quality of care in those facilities. OHCQ monitors state health care facilities under its jurisdiction to ensure compliance with all applicable state and federal regulations.

OHCQ ordered that OB/GYN Care immediately cease providing surgical abortions, determining that the public health, safety or welfare imperatively required emergency action.

9. Among other findings, the OHCQ concluded that OB/GYN Care's Baltimore office "was not equipped to complete a procedure safely . . . failed to implement a safe discharge plan for the patient . . . [which] . . . could have resulted in serious or life-threatening harm or death to the patient."

10. After reviewing these investigative findings, the Board issues this Order for Summary Suspension pursuant to Md. State Gov't Code Ann. § 10-226(c)(2). The Board concludes that the Respondent's actions constitute a substantial likelihood of risk of serious harm to the public health, safety and welfare, which imperatively requires the immediate suspension of his license to practice medicine.

OHCQ Investigation

11. OHCQ initially inspected OB/GYN Care's surgical abortion facilities in February 2013, during which time it found numerous deficiencies in its operations. After considering these findings, the Secretary of the Department of Health and Mental Hygiene summarily suspended the licenses of OB/GYN Care's Baltimore, Cheverly and Silver Spring offices, concluding that there was a threat to the public health and safety.

12. OHCQ found that OB/GYN Care's Cheverly facility was in violation of COMAR 10.12.01.09 because (a) the pads of its Automated External Defibrillator ("AED") expired in 2008; (b) the clinical nurse on site did not know how to use the AED and suction machine; (c) the District Manager admitted to the surveyor that the nurses

had not been trained on the use of the AED and suction machine; and (d) the suction machine did not work because an adapter was missing.

13. OHCQ found that OB/GYN Care's Baltimore and Silver Spring locations violated COMAR 10.12.01.07A and B by failing to perform surgical abortion services in a safe manner and by failing to develop appropriate post-anesthesia procedures and protocols. During the survey, OHCQ inspectors investigated an abortion that was performed by a staff physician ("Physician A") on February 26, 2013, at the Silver Spring office. OHCQ investigators found that Physician A left a patient unattended for a period of time after he administered conscious sedation to her and performed an abortion, and that his actions constituted a violation of COMAR 10.12.01.07B(4).

14. OHCQ investigators also investigated the circumstances surrounding an abortion that was performed by another staff physician ("Physician B") on February 13, 2013, at the Baltimore office. OHCQ investigators found that Physician B, who had administered conscious sedation and performed an abortion on a patient, left the patient unattended for a period of time. The patient reportedly became hypoxic, after which Physician B, who was not currently certified in life support services, performed resuscitation efforts. OB/GYN Care staff contacted emergency services and the patient was transported to a hospital, where she died on February 15, 2013. According to OHCQ records, the patient died of severe pulmonary edema, acute respiratory distress syndrome and hypoxic brain injury.

15. The Secretary subsequently lifted the suspensions of the clinics' licenses pending OB/GYN Care's submission of acceptable written correction plans. To date, however, OB/GYN Care has not filed acceptable plans of correction for all of the

deficiencies at each site. In addition, OB/GYN Care has not responded to repeated telephone calls and emails from OHCQ and is thus not in compliance with the regulations for abortion facilities in this State.

16. OHCQ then received an anonymous complaint, dated May 7, 2013, regarding treatment a patient (the "Patient") received at OB/GYN Care's Baltimore office on May 4, 2013, a date when Physician A was scheduled to perform abortions. This complaint revealed that OB/GYN Care continued to violate provisions of the State's surgical abortion facility regulations.

17. The complaint stated that the Patient presented to OB/GYN Care's Baltimore office on May 4, 2013, for a scheduled appointment for an abortion. At the time, no physician was on site. OHCQ's investigation revealed that untrained/unlicensed OB/GYN Care staff persons performed unsupervised, non-delegable medical acts, without the presence of a physician.

18. An OB/GYN Care employee, who holds no health care license or certification, asked the Patient to complete initial paperwork and then performed an ultrasound on her that revealed multiple gestations. The employee had no training or demonstrated competency in performing ultrasounds. The employee then asked the Patient to sign a form giving consent for a surgical abortion and for the administration of misoprostol, a medication that is used to induce abortions. The employee administered the misoprostol to the Patient when no physician was present in the facility and before any physician or licensed health care professional had any contact with the Patient.

19. Physician A then arrived at the office and determined that the Patient, due to multiple gestations, had a 22-week sized uterus. Physician A declined to complete a

surgical abortion, stating that the facility was not equipped to perform the procedure safely.

20. Physician A verbally offered the Patient three options: (a) The Patient could travel in two days to OB/GYN Care's Frederick office for the administration of laminaria, a type of seaweed that is used to dilate the cervix, and additional misoprostol, with follow-up the following day in OB/GYN Care's Baltimore facility for a dilatation and curettage ("D & C") and follow-up the day after that in OB/GYN Care's Cheverly or Silver Spring office for a second D & C, if needed; (b) An OB/GYN Care employee could transport the Patient to a site in New Jersey where a surgical abortion could be performed with the Patient under general anesthesia; or (c) The Respondent could attempt to identify a local hospital that could complete a surgical abortion procedure.

21. The Patient reportedly chose the first option and left the facility. OB/GYN Care staff provided no written discharge instructions. The Patient's medical record did not accurately describe what occurred and what was discussed with the Patient during the encounter. Later that day, the Patient presented to another facility where the staff completed a surgical abortion procedure with no reported complications.

22. On May 8, 2013, OHCQ inspectors went to OB/GYN Care's Baltimore office during the facility's reported hours of operation to investigate the complaint. The office was closed at that time in violation of COMAR 10.12.01.04A(2).

23. OHCQ investigation determined that OB/GYN Care initiated a surgical abortion in a facility that was not equipped to complete the procedure safely. In addition, OB/GYN Care failed to implement a safe discharge plan for the Patient. These

deficiencies constitute violations of COMAR 10.12.01.07A and 10.12.01.01A, which could have resulted in serious or life-threatening harm or death to the Patient.

24. The Respondent was the Medical Director at OB/GYN Care's offices during which time the offices were in violation of numerous provisions of the State's surgical abortion regulations. According to OHCQ, those violations could have resulted in serious or life-threatening harm or death to patients. To date, OB/GYN Care has not submitted a satisfactory plan of correction for the deficiencies at its offices. As Medical Director of OB/GYN Care, the Respondent was responsible for the overall medical care provided by its facilities. He failed in his professional responsibility to ensure that its offices were in compliance with the State's surgical abortion facility regulations, despite being placed on notice of such deficiencies.

25. In addition, the Respondent participated in a practice arrangement at OB/GYN Care in which unauthorized persons practiced medicine. These individuals performed ultrasounds, dispensed medications that can promote labor/abortions, and independently initiated treatment in violation of COMAR 10.32.12.04.

26. Based on these facts, the Board concludes that the Respondent constitutes an imminent threat to the public, which imperatively requires the suspension of his license.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2009 Repl. Vol. and 2012 Supp.).

ORDER

It is, by the affirmative vote of a majority of the quorum of the Board considering this case:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann. §10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that a post-deprivation hearing in accordance with Code of Maryland Regulations tit. 10, § 32.02.05.B(7), C and E on the Summary Suspension has been scheduled for **Wednesday, June 12, 2013 at 11:00 a.m.**, at the Maryland State Board of Physicians, 4201 Patterson Avenue, Room 108, Baltimore, Maryland 21215-0095; and it is further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, request an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an administrative law judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's investigator the following items:

(1) his original Maryland License D15506;

(2) his current renewal certificate;

(3) DEA Certificate of Registration, # AP2055855 (exp. 03/31/14);

(4) Maryland Controlled Dangerous Substance Registration, # M06268 (exp. 08/31/14);

(5) All controlled dangerous substances in his possession and/or practice;

(6) All Medical Assistance prescription forms;

(7) All prescription forms and pads in his possession and/or practice; and

(8) Any and all prescription pads on which his name and DEA number are imprinted.

AND IT IS FURTHER ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol. and 2012 Supp.); and it is further

ORDERED that during the period of **SUMMARY SUSPENSION**, in accordance with the provisions of Title 4, subtitle 3 of the Health-General Article, the Respondent shall have a continuing duty, on proper request, to provide the details of a patient's medical record to the patient, another physician or hospital; and it is further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol. and 2012 Supp.).

May 29, 2013
Date

Andrea Mathias, M.D., MPH
Board Chair
Maryland State Board of Physicians