IN THE MATTER OF	BEFORE THE MARYLAND
ANNA STANISLAWA BEREZIEWICZ, D.O.	STATE BOARD
Respondent	OF PHYSICIANS
LICENSE NO.: H0095251	Case Number: 2226-0056 A

CONSENT ORDER

On September 8, 2026, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **ANNA STANISLAWA BEREZIEWICZ, D.O.** (the "Respondent"), License Number **H0095251**, under the Maryland Medical Practice Act (the "Act") codified at Md. Code Ann., Health Occupations ("Health Occ.") §§ 14-101 *et seq.* (Lexis Nexis 2025 Supp.).

Specifically, Disciplinary Panel A charged the Respondent with violating the following provisions of the Act:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations — Grounds.**
>
> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> . . . .
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> (3) Is guilty of:
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> . . . .
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> (ii) Unprofessional conduct in the practice of medicine;
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> . . . .

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [or]

. . . .

(40) Fails to keep adequate medical records as determined by appropriate peer review[.]

AMA OPINION 2.1.3 (2016)[1]

AMA Opinion 2.1.3, entitled, *Withholding Information from Patients*, adopted in 2016, states in pertinent part:

> Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy. . . . Except in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient's knowledge or consent is ethically unacceptable. . . . With respect to disclosing or withholding information, physicians should:
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> . . . .
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> (f) Disclose medical errors if they have occurred in the patient's care, in keeping with ethics guidance.

On November 4, 2026, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

[1] The Board and the disciplinary panels may consider the Principles of Ethics of the American Medical Association ("AMA"), but those principles are not binding on the Board or the disciplinary panels. See the Code of Maryland Regulations 10.32.02.16.

FINDINGS OF FACT

Panel A finds:

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in the State of Maryland on August 10, 2022, under License Number H0095251. The Respondent's license to practice medicine in the State of Maryland expires on September 30, 2028, subject to renewal.

2. At all times relevant hereto, the Respondent practiced Emergency Medicine at a hospital (the "Hospital") located in Anne Arundel County, Maryland.[2]

3. On or about June 9, 2025, the Board received a Mandated 10-day Report (the "Report") from the Hospital. The Report notified the Board that, on or about June 4, 2025, the Hospital placed the Respondent on administrative leave "as a result of a clinical event in which [the Respondent] performed a wrong site thoracentesis." The Report further notified the Board that the Hospital terminated the Respondent's employment on June 6, 2025.

4. Following receipt of the Report, the Board initiated an investigation of the Respondent's practice.

[2] For confidentiality and privacy reasons, the names of individuals and private health care facilities are not disclosed in this Consent Order.

II. BOARD INVESTIGATION

5. On or about September 30, 2025, the Board sent the Respondent a letter, requesting that the Respondent provide a response to the Hospital's Report. On or about October 27, 2025, the Respondent provided a response (the "Respondent's Response"). In the Respondent's Response, the Respondent acknowledged performing a thoracentesis on a patient (the "Patient") "on the left side, which was the 'wrong site'." The Respondent stated that she "quickly realized her mistake when no fluid returned." The Respondent further stated that "[s]he withdrew the needle, performed an ultrasound, reviewed the prior x-ray, secured new supplies, and successfully completed the thoracentesis on the right side." The Respondent stated that "this error could have been avoided if [she] had followed her normal pattern and practice of completing a 'time out' to confirm laterality using ultrasound and imaging studies prior to performing the procedure."[3]

6. On or about December 8, 2025, the Board issued separate *subpoenas duces tecum* to the Hospital, directing the Hospital to produce complete unredacted copies of (i) imaging and (ii) medical records for the Patient. On or about December 9, 2025, the Hospital produced responsive imaging and medical records. According to the records, on or about June 2, 2025, the Patient presented to the Hospital with worsening shortness of breath over the past month. Radiographical imaging of the chest revealed a large right-sided pleural effusion. The Patient came under the care of the Respondent, who initially performed a left-sided thoracentesis. After failing to aspirate pleural fluid, the Respondent

[3] A "time out" is a pause taken by the entire team immediately before an invasive procedure begins to confirm the correct patient, procedure, and site.

performed a bedside ultrasound and was unable to visualize the effusion. The Respondent exited the room to review radiographical imaging of the chest. The Respondent returned to the room and informed the Patient that the "procedure will need to be redone." The Respondent performed a right-sided thoracentesis and successfully aspirated pleural fluid. After completing the procedure, the Respondent entered a note in the Patient's medical records but failed to document the left-sided thoracentesis. On or about June 4, 2025, the Respondent entered an addendum, documenting the left-sided thoracentesis.

7. On or about January 12, 2026, the Board sent the Respondent a letter, requesting that the Respondent provide a summary of care for the Patient. On or about February 6, 2026, the Respondent provided a summary of care (the "Respondent's Summary of Care"). In the Respondent's Summary of Care, after returning to the room following the left-sided thoracentesis, the Respondent "regret[s] not advising the [P]atient at that time that [she] had inadvertently started the procedure on the wrong side." The Respondent further acknowledged that she "did not correct the procedure note to reflect what occurred and sincerely wish[es] that [she] had done so."

8. The Board referred the Respondent's treatment of the Patient for peer review. The Board sent two peer reviewers (the "Peer Reviewers"), each board-certified in Emergency Medicine, copies of the Hospital's Report, the Respondent's Response, imaging and medical records for the Patient, and the Respondent's Summary of Care. The Peer Reviewers submitted reports to the Board, addressing whether the Respondent met appropriate standards for the delivery of quality medical care and kept adequate medical records.

9. The Peer Reviewers independently concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records.

10. With respect to the failure to meet appropriate standards for the delivery of quality medical care, the Peer Reviewers found that:

a. The Respondent failed to perform a "time out" prior to starting the procedure;

b. The Respondent failed to inform the Patient that the Respondent performed a left-sided thoracentesis rather than a right-sided thoracentesis; and

c. The Respondent failed to obtain informed consent from the Patient prior to performing the right-sided thoracentesis.

11. With respect to the failure to keep adequate medical records, the Peer Reviewers found that:

a. The Respondent failed to document the failure to conduct a "time out" prior to starting the procedure; and

b. The Respondent failed to document the left-sided thoracentesis.

12. On or about April 29, 2026, the Board sent the Respondent a letter, providing the Respondent an opportunity to submit a written response to the peer reviewers' reports. On or about May 18, 2026, the Respondent submitted a written response, stating that she "has conceded that she did not conduct the standard 'timeout' process and/or her normal and customary informed consent discussion." The Respondent further stated that "she should have discussed the second procedure on the correct side with the [P]atient and obtained [the Patient's] consent to proceed."

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other locations in this State, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby:

ORDERED, that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **ONE (1) YEAR.**[4] During probation, the Respondent shall comply with the following terms and conditions of probation:

Within **SIX (6) MONTHS** of the effective date of this Consent Order, the Respondent is required to take and successfully complete courses in **medical ethics** and **recordkeeping**. The following terms apply:

(a) It is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses begin;

[4] If the Respondent's license expires during the period of probation, the probation and any conditions will be tolled.

(b) The Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(c) The courses may not be used to fulfill the continuing medical education credits required for license renewal; and

(d) The Respondent is responsible for the cost of the courses; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that a violation of probation constitutes a violation of this Consent Order; and it is further

ORDERED that this Consent Order shall not be amended or modified, and future requests for modification will not be considered by the Board or a disciplinary panel; and it is further

ORDERED that after the Respondent has fully and satisfactorily complied with all terms and conditions of probation, and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss her petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all the probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

CONSENT

I, Anna Stanislawa Bereziewicz, D.O, acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

11/10/2024
Date

Anna Stanislawa Bereziewicz, D.O.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 10th day of November 2026, before me, a Notary Public of the foregoing State and City/County, Anna Stanislawa Bereziewicz, D.O., personally appeared and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

GABRIELA M FLORES BOTEO
Notary Public - Maryland
Baltimore City
My Commission Expires
09/23/2029

Notary Public

My Commission expires: 9/23/2029

ACCEPTANCE

I, Christine A. Farrelly, sign this **CONSENT ORDER** on behalf of Disciplinary Panel A.

Signature on File

11/12/2026
Date

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians