IN THE MATTER OF	*	**BEFORE THE MARYLAND**
KENDRA E. BAUER, PA-C	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: C05501	*	**Case Number: 2217-0011A**

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CONSENT ORDER

On September 6, 2018, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **KENDRA ELIZABETH BAUER, PA-C,** (the "Respondent"), License Number C05501, with violating the Maryland Physician Assistants Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 15-314(a)(3)(ii) and (22) (2014 Repl. Vol. 2017 Supp.).

The pertinent provisions of the Act provide:

> (a) Subject to the hearing provisions of §15-315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:
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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[and]
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> ...
>
> (22) Fails to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

FINDINGS OF FACT

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice as a Physician Assistant in the State of Maryland. The Respondent was originally licensed by the Board on September 4, 2014 under license number C05501. The Respondent's license is scheduled to expire on June 30, 2019.
2. On August 28, 2014, the Respondent was certified by the National Commission on Certification of Physician Assistants under identification number 1120125. This certification is valid through December 31, 2018.
3. The Respondent was employed as a Surgical Physician Assistant at Facility 1[1] from October 20, 2014 through February 3, 2017.
4. The Respondent was most recently employed as a Physician Assistant at Facility 2 from July 17, 2017 through December 21, 2017.
5. On or about February 17, 2017, the Board received a Mandated 10-day Report[2] (the "Report") from Facility 1. The report indicated that the Respondent had been terminated as a result of breaking sterile protocol during an operative cardiac procedure that was performed on Patient 4,

[1] To ensure confidentiality and privacy, the names of individuals and entities involved in this case, other than the Respondent, are not disclosed in this document.

[2] Md. Code Ann. H.O. §§14-413(a)(2)(i) and 14-414(a)(2)(i) require that within 10 days of an action hospitals report any action taken against a licensed physician which denies, restricts, limits, changes, removes, terminates, suspends, or places any conditions or restrictions on the privileges and/or salaries or contractual employment of the physician for reasons that might be grounds for disciplinary action under provisions of H.O. § 14-404 as determined by the Board.

despite having recently been placed on a Performance Improvement Plan ("PIP"), which was subsequently extended to allow the Respondent to make continued improvements regarding her communication, and surgical skillset.

6. Based on the Report, the Board initiated an investigation of the Respondent.
7. On or about February 27, 2017, Board staff informed the Respondent of the investigation and requested a written response to the allegations. Board staff also subpoenaed the Respondent's personnel file from Facility 1.
8. On or about March 15, 2017, Board staff received the Respondent's written response.
9. On or about March 29, 2017, Board staff received the Respondent's personnel file from Facility 1.
10. Between approximately April 20, 2017 and May 25, 2017, Board staff conducted interviews with three fact witnesses: MG, RK, and EC.
11. On or about July 31, 2017, Board staff subpoenaed six patient medical records from Facility 1, which were received on August 16, 2017.
12. On or about December 1, 2017, Board staff sent the Respondent a subpoena to appear for an interview. On December 18, 2017, the Respondent, with her attorney present, was interviewed by Board staff.
13. The Respondent stated that during the incident which prompted the Report, she noticed bleeding from the Patient 4's abdominal drain, which was not related to the current procedure. The Respondent then requested a "topper gauze sponge" from a staff member, but was not provided with one. At this

point she retrieved several sponges from "a large stack of opened, unused, clean…sponges on the floor." The Respondent states that the patient's incision was "not in the sterile field," and that the incident occurred when she was "no longer sterile."

14. On or about January 5, 2018, Board staff issued a subpoena for the Respondent's personnel file to Facility 2. On or about February 22, 2018, Facility 2 submitted the documents in response to the Board's subpoena.

15. On or about January 25, 2018, Board staff transmitted the six patient medical records along with summaries of care to a peer review entity, which provided the records to a surgical physician assistant for independent review.

16. Upon review of the records, the peer reviewer determined that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care with respect to two of the six patients.

I. PATIENT-SPECIFIC ALLEGATIONS

PATIENT 1

17. Patient 1, a male born in the 1940's, presented with a history of coronary artery disease, symptomatic aortic stenosis, hypertension, and deep vein thrombosis, and was status-post a bilateral total knee replacement. Patient 1 also had a history of tobacco smoking and aspirin use over a prolonged period.

18. Patient 1 underwent coronary angiography,[3] and as a result was referred for coronary artery bypass grafting ("CABG"),[4] and aortic valve replacement[5] surgery. This surgery took place on or about December 20, 2016.

19. On or about December 20, 2016, the Respondent was assigned as the second assistant during Patient 1's surgical procedures, along with the lead Cardiac Physician Assistant.

20. The Respondent performed an endoscopic vessel harvest ("EVH") on Patient 1 in the presence of the lead Physician Assistant. The Respondent described the harvest as "difficult." During the performance of the procedure, the harvest became prolonged, and the Respondent ultimately had to request assistance from the Chief Physician Assistant who was able to place a Jackson-Pratt ("JP") Drain[6] in the left leg and complete the EVH. As a result the surgery was prolonged with a bypass time of 212 minutes.

21. After weaning Patient 1 off of cardiopulmonary bypass, the surgeon noted that there was a large hematoma[7] in the left EVH site. This required re-exploration and subsequent re-closure of the EVH incision, with the attending surgeon noting that "a large amount of blood was evacuated."

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[3] Coronary Angiography is a procedure that uses contrast dye and x-ray imaging to detect blockages in the coronary arteries caused by plaque buildup, as defined by the National Institutes of Health.
[4] Coronary Artery Bypass Grafting is a type of surgery that improves blood flow to the heart, according to the National Heart, Lung, and Blood Institute.
[5] Aortic Valve Replacement, as defined by Johns Hopkins Medicine, is a minimally invasive surgery to replace a poorly working aortic valve with an artificial valve.
[6] A Jackson-Pratt Drain is a closed-suction medical device that is commonly used as a post-operative drain for collecting bodily fluids from surgical sites.
[7] Hematoma is a collection of extravasated blood trapped in the tissues of the skin or in an organ, resulting from trauma or incomplete hemostasis after surgery, as defined in Mosby's Medical Dictionary.

22. On or about December 23, 2016, which was post-operative day ("POD") three, the attending surgeon noted "left leg fullness with ecchymosis[8] around lower abdomen and back – sec[ondary] to saphenectomy[9]." However, an ultrasound revealed that no treatment was required and Patient 1 was discharged on POD six.

23. On or about January 5, 2017, Patient 1 was re-admitted to the hospital with redness and firmness of the left thigh, as well as fever and leukocytosis.[10] A scan of Patient 1's left leg was completed and showed a subacute hematoma with no evidence of active infection. Due to the recent surgery, Patient 1 was admitted for a seven day course of intravenous antibiotics before being discharged on January 13, 2017 without further surgical intervention.

24. The Respondent's conduct, as set forth above, constitutes unprofessional conduct in the practice of medicine, as well as failure to meet appropriate standards for the delivery of quality medical care regarding Patient 1, in violation of Health Occ. § 15-315(a)(3)(ii), and (22), for reasons including:

    a. Failing to recognize the amount of time needed for a difficult EVH, and inform the lead surgeon or fellow that more time was needed, particularly in light of the Respondent's previous PIP addressing this very issue;

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[8] Ecchymosis is a discoloration of the skin caused by subcutaneous bleeding.
[9] Saphenectomy is the removal of the great saphenous vein.
[10] Leukocytosis is defined as having an elevated white blood cell ("WBC") count.

b. Failing to recognize large amounts of bleeding coming from the drain site and inform the operative surgeon of the presence of a large hematoma, which should have been easily apparent on visual inspection of the leg; and

c. Failure to institute the standard of quality care when there is excessive bleeding during an EVH including the following measures: place a drain, wrap the leg with an ACE bandage, place a towel over the EVH tract to apply pressure, and delay the closure of the EVH incision until after protamine has been administered.

PATIENT 4

25. Patient 4, a male born in the 1950's, presented with a history of gastritis, fatty liver, and asthma. Patient 4 was status post a colon resection[11] for cancer, and a subsequent Computed Tomography ("CT") scan revealed a pancreatic cyst. Patient 4 was then admitted for an elective Whipple Procedure[12] and liver biopsy.

26. On or about January 10, 2017, Patient 4 underwent the Whipple Procedure at Facility 1, where the Respondent acted as second assistant.

27. At the conclusion of the surgical procedure, drapes were removed from Patient 4 and sterile dressings were applied to the chest incision. At this point

[11] Colon Resection is a surgery to remove a part of the bowel.
[12] The Whipple Procedure is also known as a pancreaticoduodenectomy, and is the primary surgical treatment for pancreatic cancer.

the Respondent used five counted, nonsterile RayTec sponges lying on the floor to cleanse the previous Whipple incision, as well as the abdominal JP drain site which was bleeding.

28. In her written response addressing this "RayTec incident," the Respondent states that she requested "Topper" sponges but was "given" RayTec sponges instead to clean and dress the wound and drain site. Upon being questioned by nursing staff about where the RayTec sponges came from the Respondent stated that "they were just there," on Patient 4's abdomen.

29. On or about February 3, 2017, Facility 1 terminated the Respondent's employment based in-part upon this incident.

30. The Respondent's conduct, as set forth above, constitutes unprofessional conduct in the practice of medicine, as well as failure to meet appropriate standards for the delivery of quality medical care regarding Patient 4, in violation of Health Occ. § 15-315(a)(3)(ii), and (22), for reasons including:

    a. Failing to follow proper sterile protocol during a surgical procedure; and

    b. Failing to show basic initiative to retrieve the appropriate Toppper sponges instead of using nearby non-sterile, unclean RayTec sponges off of the floor for use in cleaning and dressing Patient 4's abdomen.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel A of the Board concludes as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 15-314(a)(3)(ii), and of failing to meet appropriate standards for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of Health Occ. § 15-314(a)(22).

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.**[13] During probation, the Respondent shall comply with the following terms and conditions of probation:

1. The Respondent shall enroll in the Maryland Professional Rehabilitation Program (MPRP) as follows:

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

(a) Within 5 business days of the effective date of this Consent Order, the Respondent shall contact MPRP to schedule an initial consultation for enrollment;

(b) Within 15 business days of the effective date of this Consent Order, the Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP;

(c) the Respondent shall fully and timely cooperate and comply with all MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and screenings as directed by MPRP;

(d) the Respondent's failure to comply with any term or condition of the Participant Rehabilitation Agreement(s) or Participant Rehabilitation Plan(s) constitutes a violation of this Consent Order;

(e) the Respondent shall sign and update the written release/consent forms requested by the Board and MPRP, including release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from MPRP records and files in a public order. A failure to, or withdrawal of consent. is a violation of this Consent Order;

(f) the Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including, but not limited to, mental health and drug or alcohol evaluation and treatment records;

2. The Respondent shall comply with the Maryland Physician Assistants Act, Md. Code Ann., Health Occ. §§ 15-101—15-502, and all federal and state laws and regulations governing the practice of medicine in Maryland.

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

ORDERED that after the Respondent has 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 his petition for termination. The disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel if there are no pending complaints relating to the charges; and it is further

ORDERED that a violation of probation constitutes a violation of the Consent Order; 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 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 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 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 the Respondent is responsible for all costs incurred in fulfilling 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).

01/02/2019
Date

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

CONSENT

I, Kendra E. Bauer, PA-C., 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 these rights and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusions 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 own 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.

12/21/18
Date

Signature on File

Kendra E. Bauer, PA-C
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 21st day of December 2018, 2018, before me, a Notary Public of the foregoing State and City/County personally appear Kendra E. Bauer, PA-C, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

DIANNA L. NELSON
Notary Public
Harford County
Maryland
My Commission Expires Nov. 03, 2020

Dianna L Nelson
Notary Public

My commission expires: 11-03-2020