IN THE MATTER OF	*	**BEFORE THE**
ESFAND NAWAB, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D13630	*	**Case Number: 2218-0245A**

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CONSENT ORDER

On May 23, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **Esfand Nawab, M.D. (A.K.A. Esfandiar Nawab),** (the "Respondent"), **License Number D13630,** with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2014 Repl. Vol. & 2018 Supp.).

The pertinent provisions of the Act provide:

> (a) *In general.* – Subject to the hearing provisions of §14-405 of this subtitle, a disciplinary pane, 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:
>
> . . .
>
> (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;
>
> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review [.]

On September 11, 2019, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

Panel A finds:

Background

1. At all times relevant to these charges, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in the State of Maryland on or about February 2, 1979. His license is current through September 30, 2019.

2. The Respondent is board-certified in obstetrics and gynecology, and until March 31, 2018, had an office-based practice located in Bethesda, Maryland, when he reportedly retired from the practice of medicine.

3. At times relevant to these charges, the Respondent held hospital privileges at three hospitals, two located in Maryland (Hospitals A and B) and one located in the District of Columbia.[1]

4. The Respondent is actively licensed in Virginia through February 2020. The Respondent's District of Columbia medical license expired in December 2018.

[1] In order to maintain confidentiality, identifying names will not be used for facilities, patients or personnel.

5. On or about March 28, 2018, the Board received a Mandated 10-Day report from Hospital A notifying the Board that Hospital A had accepted the Respondent's voluntary resignation after "identifying clinical issues" with a single patient ("Patient A"). The "clinical issues" involved the Respondent's surgical care and treatment of Patient A before, during and after a February 20, 2018 gynecologic surgical procedure.

6. On or about August 14, 2018, the Board notified the Respondent that it had initiated an investigation into his practice based on the receipt of the Mandated 10-Day report.

7. On or about September 14, 2018, the Respondent filed an initial written response with the Board.

8. The Board subsequently subpoenaed and received from Hospital A the Respondent's employment records and Patient A's medical records.

9. The Board transmitted Patient A's records and other relevant documents for peer review by two physicians board-certified in obstetrics and gynecology (the "peer reviewers").

10. On or about November 19, 2018, the peer reviewers submitted reports to the Board, the results of which are set forth in pertinent part below.

11. On or about December 10, 2018, the Respondent filed a Supplemental Response with the Board after receiving copies of the peer review reports.

Hospital A investigation and peer review

12. On or about February 21, 2108, Dr. A, an anesthesiologist assigned to Patient A's February 20 surgical procedure with the Respondent, sent an email to the Vice President

for Medical Affairs at Hospital A. Dr. A stated in the email that Patient A had been scheduled by the Respondent for a supracervical hysterectomy due to the rupture of a tubo-ovarian abscess, and subsequently Patient A experienced multiple complications including an open abdomen, massive blood loss requiring transfusion with multiple units of blood, hypotension and a transfer to the Intensive Care Unit intubated. Dr. A expressed concern that the Respondent appeared to be "unaware" of the amount of blood Patient A was losing during the procedure and according to Dr. A, the Respondent made no attempt to control the blood loss and did not appear to have any understanding of how to control the blood loss. Dr. A's impression was that the Respondent was not in "control" of the situation and he informed Hospital A that he refused to perform any further cases with Dr. A.

13. On or about February 21, 2018, PA-C, a physician assistant assigned to Patient A's February 20 surgical procedure with the Respondent, sent an email to her supervisor expressing several concerns about the Respondent's conduct and performance pre-operatively and intra-operatively including but not limited to surgical technique and initial resistance to consult with a general surgeon despite extensive pelvic adhesions that made it difficult to identify Patient A's anatomy.

15. On or about February 22, 2018, Dr. B, the general surgeon who was ultimately called in to assist the Respondent with Patient A's surgery, provided a written statement to Hospital A. Dr. B stated that he had been called in to assist the Respondent after the Respondent injured Patient A's sigmoid colon during the procedure. Dr. B stated that when he arrived, Dr. A was in the process of transfusing Patient A with packed red blood

cells (she ultimately received seven units), and that she was hypothermic and acidotic. Dr. B assumed the lead for the remainder of Patient A's surgery. Patient A received additional transfusions of fresh frozen plasma and platelets. After the surgery was "aborted" she was transferred to the Intensive Care Unit in critical condition.

16. Dr. B noted several concerns regarding the Respondent's surgical care of Patient A in a written memorandum he provided to Hospital A including but not limited to whether a hysterectomy was necessary, the source of Patient A's blood loss, why Patient A's bowel injury was not promptly repaired or an attempt made to prevent fecal contamination, whether the Respondent had provided informed consent to Patient A, and a concern that the Respondent had altered the Consent for Surgery form after Patient A had signed the document. Lastly, Dr. B raised as an issue that the Respondent had not been aware of Patient A's family members in order to be able to communicate "postoperative findings and events."

17. On or about February 26, 2018, Hospital A noted in a letter to the Respondent that the hospital was concerned about his ability to handle "difficult and emergent operations."

18. By letter dated March 7, 2018, the Respondent resigned from Hospital A's staff, and by letter dated March 26, 2018, Hospital A accepted his resignation.

Peer Review

Standard of Quality Care violations

19. Patient A was a female in her 40s who presented to Hospital A's emergency room ("ER") on the evening of February 19, 2018, with complaints of abdominal pain, fever,

headache, back pain, dizziness, nausea and emesis. The ER staff conducted testing, and during the morning of February 20, 2018, the Respondent documented that Patient A "was an emergency requiring laparotomy and removal of infected organs." The Respondent planned to perform an exploratory laparotomy for bilateral tubo-ovarian abscesses and sepsis. Patient A had a history of two prior myomectomies, uterine fibroids and anemia.

20. During Patient A's procedure, she had extensive blood loss of approximately three liters, and the Respondent injured her large bowel. Dr. B was called in to complete the surgery, which was a supracervical hysterectomy with bilateral salpingo-oophorectomies ("BSO"), a bowel repair and a colostomy.[2] Dr. B had to abort the procedure before completion because of Patient A's instability.

21. The standard of quality care for a patient presenting with tubo-ovarian abscess(es) includes intravenous antibiotics and supportive care for 24-48 hours, with possible abscess drainage. Ultimately, if a patient appears toxic and/or septic urgent surgical abscess drainage and debridement is necessary, with the possibility of a hysterectomy with BSO.

22. The peer reviewers concurred that the Respondent failed to meet the standard of quality care to Patient A for reasons including but not limited to the following:

a. the Respondent failed to evaluate Patient A in a timely manner the evening he was notified, instead waiting until the following morning to see her;

[2] Prior to Patient A's discharge from Hospital A, Dr. B completed three additional surgeries on her for abdominal wash out, colostomy closure and debridement with wound vacuum placement.

b. the Respondent failed to allow 24-48 hours of antibiotic treatment before proceeding with surgery;

c. the Respondent failed to attempt or explore other options for abscess drainage and proceeded directly to an open procedure (laparotomy);

d. the Respondent failed to timely consult with a general surgeon or gynecologic oncologist when he discovered Patient A presented with a "frozen pelvis";

e. the Respondent's surgical technique and control of the stability of Patient A;

f. the Respondent failed to attempt to avoid performing a hysterectomy in Patient A, who was a nulliparous patient, and there was no documentation that she did not desire childbearing or that the removal of the uterus was emergent.

Inadequate documentation

23. The peer reviewers concurred that the Respondent's recordkeeping was inadequate for Patient A for reasons including but not limited to the following:

a. the Respondent failed to adequately document the surgical complications including the estimated blood loss;

b. the Respondent failed to adequately document Patient A's postoperative care;

c. the Respondent added surgical procedures (hysterectomy and bilateral salpingo-oophorectomies) to Patient A's Informed Consent Form without co-signature by Patient A;

d. the Respondent failed to document any attempts to contact Patient A's family postoperatively

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent failed to meet the standard of quality medical care, in violation of Health

Occ. § 14-404(a) (22), and that the Respondent failed to keep adequate medical records, in violation of Health Occ. § 14-404(a) (40).

ORDER

It is thus by Disciplinary Panel A of the Board, hereby:

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

ORDERED that the Respondent is permanently prohibited from performing all surgical procedures; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not performed any surgical procedures in the past year; and it is further

ORDERED that if the Respondent fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that the Respondent has violated the permanent condition; and

(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; 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, 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 the disciplinary panel determines 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 with appropriate terms and conditions, 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 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).

October 1, 2019
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Esfand Nawab, M.D., 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.

Signature on File

09/25/19
Date

Esfand Nawab, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 25th day of September 2019, before me, a Notary Public of the foregoing State and City/County, personally appeared Esfand Nawab, M.D., 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 notarial seal.

Notary Public

My Commission expires: 3/26/22